

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered October 14, 2022

Administrator Maplewood Court Assisted Living 310 7th Street Northeast Fulda, MN 56131

RE: Project Number(s) SL30343015

Dear Administrator:

On September 29, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on August 10, 2022. This follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the August 10, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on August 10, 2022, found not corrected at the time of the September 29, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0470-Minimum Requirements-144g.41 Subdivision 1 - \$500.00 1290-Background Studies Required-144g.60 Subdivision 1 1470-Content Of Required Orientation-144g.63 Subd. 2

The details of the violations noted at the time of this follow-up evaluation completed on September 29, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the total amount you are assessed is \$500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

- Level 1: no fines or enforcement.
- Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
- Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
- Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. <u>Please note that you may request a reconsideration **or** a hearing, but not both.</u>

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jodi Johnson, Supervisor Health Regulation Division State Evaluation Team 85 East Seventh Place, Suite 220

85 East Seventh Place, Suite 220 P.O. Box 3879

6. D. J. MAN 55404 2

St. Paul, MN 55101-3879

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 651-215-9697

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30343	B. WING		R 09/29/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
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{0 000}	Initial Comments		{0 000}			
	Initial comments ******ATTENTION*** ASSISTED LIVING CORRECTION OR In accordance with 144G.08 to 144G.9 been issued pursua Determination of wh corrected requires of requirements provious indicated below. Wh contains several ite of the items will be compliance. INITIAL COMMENT Project SL3034301 On September 21, 2022, and Septemb September 29, 202 of Health conducted provider to follow-up a survey completed time of the survey, receiving services up	PROVIDER LICENSING DER Minnesota Statutes, section 5 this correction order(s) has ant to a survey. The ther a violation has been compliance with all ded at the Statute number then Minnesota Statute ms, failure to comply with any considered lack of TS: 5 2022, through September 23, per 26, 2022, through 2, the Minnesota Department d a revisit at the above p on orders issued pursuant to 1 on August 10, 2022. At the there were 41 residents: 15 under the Assisted Living of the revisit, the following		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Assis Living License Providers. The ass tag number appears in the far-left entitled "ID Prefix Tag." The state number and the corresponding test state Statute out of compliance is the "Summary Statement of Deficicolumn. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Corplease DISREGARD THE HEALTHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TOUR STATUTES. The letter in the left column is use tracking purposes and reflects the and level issued pursuant to 1440 subd. 1, 2 and 3.	oftware. to sted igned column Statute ct of the listed in encies" is the ne state This as eyors ' rection. DING OF THIS O THIS O THIS d for scope	
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Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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	determining its staf	fing level that					
	(i) includes an evalu		nducted at				
	least twice a year, o						
	staffing levels in the		iteriess of				
	(ii) ensures sufficie		times to meet				
	the scheduled and						
	unscheduled needs						
	by the residents' as						
	on a 24-hour per da		a service plans				
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	(iii) ensures that the						
	and effectively to in						
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	situations affecting						
	(12) ensure that on						
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	who are responsible						
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	safety needs. Such	persons must	be:				
	(i) awake;						
	(ii) located in the sa						
	building, or on a co						
	facility in order to re	espond within a	reasonable				
	amount of time;						
	(iii) capable of com						
	(iv) capable of prov		oning the				
	appropriate assista						
	(v) capable of follow	ving directions;					
	This MN Requireme	ent is not met a	as evidenced				
	by:	_					
	Based on interview						
	licensee failed to er						
	were available 24 h						
	week, who were res						
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	building, in an attac	hed building, o	r on a				
	contiguous campus						
	respond within a re						
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	This practice result	ed in a level tw	o violation (a				

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
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{0 470}	violation that did no safety but had the president's health or widespread scope (or represent a syste or has the potential the residents). The findings include The licensee held a license with a bed ocurrent census of 4 During the original son August 8, 2022, assisted living direct nurse (RN)-B stated during the day Monone-two unlicensed a.m. to 2:00 p.m. ar 10:00 p.m. each da between the hours staff from the attack to call lights as ther duty for the assisted LALD-A stated the finding the original staffed for "years." During the original staffed for "years." During the original staffed for "years."	tharm a resident's health or potential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all emic apacity of 46 residents: with a 0 residents. Survey's entrance conference at 11:30 a.m. licensed at 11:30 a.m. licensed at 11:30 a.m. licensed at the deside nursing coverage day through Friday, there was personnel (ULP) from 6:00 and one ULP from 2:00 p.m. to y. LALD-A and RN-B stated of 10:00 p.m. to 6:00 a.m., ned nursing home responded e was no staff specifically on d living facility during the night facility did not have a staffing ow the facility had been survey on August 9, 2022, at d nursing home administrator answer call lights for the lents during the hours of 10:00 LNHA-F stated nursing home				
		censee's residents. LNHA-F all lights were hardwired				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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{0 470}	together into the number the panel and a B:50 a.m., office may home staff that coveresidents between the 6:00 a.m., were not standards, nor were affiliated with the assindicated she had not for the nursing home requirement, stating During the original schedule dated July 2022, noted nursing coverage between 6:00 a.m. On September 22, stated the licensee staff on duty betwee 6:00 a.m. and continue staff for covelicensee had sent a home staff to answere sidents during the a.m. On the waiver to have until Octobe background checks the nursing home staff to answere to have until Octobe background checks the nursing home staff the staffin number of qualified residents' needs 24	rsing home and alerted staferial systems. survey on August 10, 2022, anager (OM)-H stated nursing the hours of 10:00 p.m. and orientated to assisted living their background studies assisted living facility. OM-H not thought of that requirements as the staff, but was aware of the	at ag at ag and ag			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _		(X3) DATE SURVEY COMPLETED		
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{0 470}	would respond to a assistance with hear reasonable amount	t-care staff and licensed staff resident's request for alth or safety needs within a of time, as provided in , section 144G.41, subdivision .	{0 470}			
{0 480} SS=F	following services to (i) at least three nut available seven day recommended dieta States Department guidelines, including fresh vegetables. T (B) food must be pr	e or make available at least the oresidents: tritious meals daily with snacks as per week, according to the ary allowances in the United of Agriculture (USDA) g seasonal fresh fruit and				
{0 810} SS=F	by: No further action re 144G.45 Subd. 2 (b physical environme (b) Each assisted I	o)-(f) Fire protection and	{0 810}			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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	(1) location and noroms; (2) employee activation a fire or similar emotion (3) fire protection residents; and (4) procedures for evacuation, or relocemergency including or unusual resident evacuation.	but are not limited to: umber of resident sleeping ons to be taken in the event of ergency; procedures necessary for r resident movement, cation during a fire or similar g the identification of unique needs for movement or essisted living facilities shall					
	receive training on plans upon hiring a thereafter. (d) Fire safety and readily available at (e) Residents who a their own evacuation proper actions to tainclude movement, training shall be maleast once per year (f) Evacuation drills twice per year per sevacuation drill eventhe residents is not activation is not readrill.	the fire safety and evacuation and at least twice per year evacuation plans shall be all times within the facility. The are capable of assisting in an shall be trained on the ke in the event of a fire to evacuation, or relocation. The ade available to residents at are required for employees shift with at least one ry other month. Evacuation of required. Fire alarm system quired to initiate the evacuation					
	This MN Requirements by: No further action re	ent is not met as evidenced quired.					
{01290} SS=E		on 1 Background studies	{01290}				
	(a) Employees, con	tractors, and regularly					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
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{01290}	Continued From particles the background sture 144.057 and may be 245C. Nothing in the construed to prohibin self-disclosure of credit (b) Data collected users of credit assified as private section 13.02, subsection 13.02, subsection 13.02, subsection 13.02, subsection 13.02, subsection regarding does not subject the liability or liability for This MN Requirements by: Based on interview licensee failed to ensubmitted and rece assisted living licen (certified nursing as practical nurse (LPI cares from the attack with records review) This practice results violation that did not safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a lim	irs of the facility are dy required by sective disqualified under is subdivision shall it the facility from retiminal conviction in under this subdivision and the data on individuals livision 12. In employee in good tion or records obtaing a confirmed contract and record review, assisted living factor unemployment be and record review, assure a background ived an affiliation was for three of sevents and LPN-R) as ched nursing home ed. The din a level two vious tharm a resident's potential to have has a safety, but was not by, impairment, or detern scope (when measidents are affected per of staff are involved.	con chapter be equiring formation. In shall be sunder difficulty to civil nefits. Videnced the study was ith the en staff censed esisting in of licensee lation (a health or med a likely to eath) and nore than a d, more ved, or the	{01290}			
	During the initial su		ference on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

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stated between the hour a.m. staff from the attack responded to call lights a specifically on duty for the during the night. LALD-not have a staffing waive facility had been staffed. During the initial survey 8:50 a.m., office manage assisting with cares betw p.m. and 6:00 a.m. from home did not have back "affiliated," but rather unlicense. OM-H indicated that requirement for the was aware of the requirement." The nursing home scheen 2022, through September 2022, through September 2022, through September CNA-M, LPN-P, and LPN-P, an	o a.m. LALD-A and RN-B rs of 10:00 p.m. to 6:00 ched nursing home as there was no staff he assisted living facility A stated the facility did er as this was how the for "years." on August 10, 2022, at er (OM)-H confirmed staff ween the hours of 10:00 in the attached nursing aground studies that were inder the nursing home did she had not thought of nursing home staff, but ement, stating "it makes and the did attend between the 16:00 a.m. CNA-M, and to have background attion with the licensee. 2, at 10:02 a.m. LALD-A and hot have assisted living the hours of 10:00 p.m. and did to rely on the nursing all lights for assisted living urs of 10:00 p.m. and 6:00 in, the licensee requested 2022, to complete did orientation training for It was her understanding	{01290}	DELICITY STATES OF THE PROPERTY OF THE PROPERT		

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STATE FORM 6899 IPJI12 If continuation sheet 8 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	complete the backg for the nursing hom	round checks and affiliations e staff.				
	dated August 1, 202 may provide direct independent direct acceptable result of been received. [Th individuals whose re	contact with any residents until f the background study have e licensee] will not employ esults of the background study tion for the position.				
{01470} SS=E	144G.63 Subd. 2 C	ontent of required orientation	{01470}			
	topics: (1) an overview of t (2) an introduction a policies and proced of assisted living se person; (3) handling of eme emergency services (4) compliance with maltreatment of vul 626.557 to the Minr Center (MAARC); (5) the assisted livin responsibilities rela and protection of th (6) the principles of and service delivery support services pr (7) handling of resic complaints, and wh	and review of the facility's dures related to the provision ervices by the individual staff ergencies and use of s; and reporting of the nerable adults under section nesota Adult Abuse Reporting and bill of rights and staff ted to ensuring the exercise				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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{01470}	Facility Complaints (8) consumer advo Ombudsman for Lo Ombudsman for Modevelopmental Dis Ombudsman at the Services, county-mother relevant advo (9) a review of the services the emplois facility's category or (b) In addition to the orientation may als services to residentraining on hearing subdivision must be based, may include include training on topics: (1) an explanation of and how it manifest the challenges it pound incidence of demer isolation, and depressionation, and depressionation, and depressionation, and depressionation, and depressionation about that may enhance of involvement, included assistive listening of and tactile alerting and tactile alerting access in real time. This MN Requirem by: Based on interview licensee failed to endorse failed to	cacy services of the Office of ong-Term Care, Office of ental Health and abilities, Managed Care Department of Human anaged care advocates, or ocacy services; and types of assisted living yee will be providing and the ficensure. The topics in paragraph (a), to contain training on providing the with hearing loss. Any loss provided under this the high quality and research to online training, and must one or more of the following of age-related hearing loss the itself, its prevalence, and the sest to communication; related to untreated gloss, such as increased that, falls, hospitalizations, tession; or out strategies and technology	{01470}			

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STATE FORM 6899 IPJI12 If continuation sheet 10 of 15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
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{01470}	the attached nursing assisted living facilial regulations before pure This practice result violation that did not safety but had the president's health or cause serious injury was issued at a patalimited number of rethan a limited number situation has occur found to be pervasional The findings included During the initial sure 8:50 a.m. office manursing home staff the hours of 10:00 peen trained on assindicated she had refor the night nursing the requirement, state During the initial sure 2:00 p.m. RN-B concrientation components. RN-B indicated only been completed as have a training in promponents. RN-E to develop somethic requirements. The nursing home evidence orientation licensing requirements.	ig home received orientation ity licensing requirements are providing services. ded in a level two violation (a set harm a resident's health or othertial to have harmed a safety, but was not likely to by, impairment, or death) and tern scope (when more that esidents are affected, more over of staff are involved, or the tree of s	r d n d he he l-H ent e of			

Minnesota Department of Health

30343 B. WING 09/29/3		
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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWOOD COURT ASSISTED LIVING 310 7TH STREET NE FULDA, MN 56131		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
(01470) Continued From page 11 -an overview of the appropriate assisted living statutes and rules -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person -handling of emergencies and use of emergency services -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of the those rightsprinciples of person-centered planning and service delivery and how they apply to direct support services provided by the staff person -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, countly-managed care advocates, or other relevant advocacy services -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. The nursing home schedule dated September 14, 2022, through September 21, 2022, identified CNA-L, CNA-M, CNA-O, LPN-P, and RN-Q worked between the hours of 10:00 p.m. and 6:00 a.m. CNA-L's record lacked evidence the required		

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 12 of 15 IPJI12

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30343	B. WING			R 29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	•	
MAPLEV	VOOD COURT ASSIST	TED I IVING	STREET NE MN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{01470}	Continued From pa	ge 12	{01470}			
	orientation to assist	ted living had been completed				
	to assisted living co	entified the required orientation ontents had been completed 2022, after the entrance of the				
		ked evidence the required ted living had been completed				
	to assisted living co	ntified the required orientation ontents had been completed 2022, after the entrance of the				
	to assisted living co	tified the required orientation ontents had been completed 2022, after the entrance of the				
	stated the licensee staff on duty betwee 6:00 a.m. and conti home staff for cove licensee had sent a home staff to answeresidents during the a.m. On the waiver to have until Octobe background checks the nursing home s	2022, at 10:02 a.m. LALD-A did not have assisted living en the hours of 10:00 p.m. and nued to rely on the nursing rage during those hours. The waiver request for nursing er call lights for assisted living e hours of 10:00 p.m. and 6:00 r form the licensee requested er 1, 2022, to complete and orientation training for taff. It was her understanding ntil October 1, 2022, to ng.				
		2022, at 3:46 p.m. LALD-A tation had not been completed	i			
	The licensee's 5.01	Orientation of Staff and				

Minnesota Department of Health

STATE FORM 6899 IPJI12 If continuation sheet 13 of 15

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30343	B. WING		09/2	? 9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLEV	VOOD COURT ASSIST	TED LIVING 310 7TH S FULDA, M	TREET NE IN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01470}	noted all staff of [Th supervising direct sorientation to assist requirements and reassisted living service orientation must consumer advisorientation must consumer advisorientation must consumer advisorientation must consumer advorage of complaints. The assisted living service of complaints of the service delivery and support services proceed assisted living services and protection of the service delivery and support services proceed assisted living services and protection of the service delivery and support services proceed assisted living services and protection of the service delivery and support services proceed assisted living services and protection of the service delivery and support services proceed assisted living services and protection of the service delivery and support services proceed assisted living services and protection of the service delivery and support services proceed assisted living services and protection of the services a	nt policy dated August 1, 2022, ne licensee] providing and ervices must complete an ed living facility licensing egulations before providing ces to residents. The ntain the following topics: the appropriate assisted living and review of the facility's ures related to the provision of ces by the individual staff ergencies and use of shand reporting of the nerable adults under section nesota Adult Abuse Reporting ing bill of rights and staff ted to ensuring the exercise ethose rights. Erson-centered planning and I how they apply to direct ovided by the staff person idents' complaints, reporting where to report complaints, n on the Office of Health end abilities, Managed Care Department of Human anaged care advocates, or cacy services types of assisted living we will be providing and the	{01470}			

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 14 of 15 IPJI12

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMI	(X3) DATE SURVEY COMPLETED	
		30343	B. WING			R
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, S		09/.	29/2022
	VOOD COURT ASSIS	310 7TH	STREET NE	TATE, ZIII OODE		
		FULDA,	MN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
{01470}	Continued From pa	ige 14	{01470}			
	No further informat	ion was provided.				



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 19, 2022

Administrator Maplewood Court Assisted Living 310 7th Street Northeast Fulda, MN 56131

RE: Project Number(s) SL30343015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 10, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

- Level 1: no fines or enforcement.
- Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
- Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
- Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation

Maplewood Court Assisted Living August 19, 2022 Page 2

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

The total amount you are assessed is \$3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please <a href="mailto:em

Maplewood Court Assisted Living August 19, 2022 Page 3

Please address your cover letter for general reconsideration requests to:

Reconsideration Unit

Health Regulation Division

Minnesota Department of Health

P.O. Box 64970

85 East Seventh Place

St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:

Reconsideration Unit

Health Regulation Division

Minnesota Department of Health

P.O. Box 64970

85 East Seventh Place

St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to Health.HRD.Appeals@state.mn.us.

To appeal fines via reconsideration, please follow the procedure outlined above. <u>Please note that you may request a reconsideration or a hearing, but not both.</u>

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor Health Regulation Division State Evaluation Team

85 East Seventh Place, Suite 220

P.O. Box 3879

St. Paul, MN 55101-3879

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30343		B. WING		08/1	0/2022
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		0.2022
MAPLEW	OOD COURT ASSIS	TED LIVING	310 7TH S FULDA, M	STREET NE IN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCY Y MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 000	Initial Comments			0 000			
	Initial comments ******ATTENTION* ASSISTED LIVING CORRECTION OF In accordance with 144G.08 to 144G.9 issued pursuant to Determination of w requires compliand provided at the Sta When Minnesota S failure to comply w considered lack of INITIAL COMMEN' SL#30343015 On August 8, 2022 Minnesota Departn survey at the above correction orders a survey, there were were receiving serv Assisted Living lice On August 10, 202 order 1290 was rer non-compliance rei (level 3, widesprea	Minnesota Statute 25, these correction a survey. hether violations are with all requirement the number indicastatute contains servith any of the items compliance. TS: through August 11 ment of Health concerns of Health concerns and the re issued. At the tile 44 residents; 18 ovices under the provider, and the re issued. At the tile 44 residents; 18 ovices under the provider, and the re issued. At the tile 44 residents; 18 ovices under the provider, and the re issued. At the tile 44 residents; 18 ovices under the provider, and the remse.	es, section norders are are corrected tents ated below. veral items, s will be		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal stag numbers have been assigned Minnesota State Statutes for Assistiving License Providers. The asstag number appears in the far left entitled "ID Prefix Tag." The state number and the corresponding testate Statute out of compliance is the "Summary Statement of Defic column. This column also include findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Contract Column and Federal Deficiencies only will appear to Correction." This Applies of Correction." This Applies of Correction." This Applies of There is no Requirement of Correction." This Applies of There is no Requirement of Correction." The Applies of Correction. There is no Requirement of Corrections of Minnesota of Statutes. There is no Requirement is used tracking purposes and reflects the and level issued pursuant to 1440 subd. 1, 2, and 3.	oftware. I to sted signed column Statute kt of the listed in iencies" s the ne state This as eyors' rrection. DING OF TO THIS ON FOR TATE	
0 470 SS=F	144G.41 Subdivision (11) develop and in	•		0 470			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30343	B. WING		08/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLEV	VOOD COURT ASSIS	TED LIVING 310 7TH S FULDA, M	STREET NE IN 56131			
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0 470	determining its staff (i) includes an evalule least twice a year, of staffing levels in the (ii) ensures sufficient the scheduled and unscheduled needs by the residents' as on a 24-hour per da (iii) ensures that the and effectively to in and to emergency, situations affecting (12) ensure that on available 24 hours who are responsibly requests of resident safety needs. Such (i) awake; (ii) located in the sabuilding, or on a confacility in order to reamount of time; (iii) capable of com (iv) capable of provappropriate assista (v) capable of follow. This MN Requiremant (v) capable of resident by: Based on interview licensee failed to en were available 24 hours who were resident building, in an attact contiguous campus respond within a resident safety of the safet	fing level that: uation, to be conducted at of the appropriateness of e facility; Int staffing at all times to meet reasonably foreseeable of each resident as required residents and service plans of facility can respond promptly dividual resident emergencies life safety, and disaster restaff or residents in the facility; or more persons are per day, seven days per week, of or responding to the residents with health or residents with health or respons must be: one building, in an attached ntiguous campus with the respond within a reasonable municating with residents; riding or summoning the nce; and	0 470			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30343	B. WING		08/1	0/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLEW	OOD COURT ASSIS	TED LIVING 310 7TH S FULDA, N	STREET NE IN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	safety but had the president's health or widespread scope or represent a syste or has the potential the residents). The findings include the residents. The findings include the residents included the residents. The findings include the residents included the residents of 4 to current census of the current census of the current census of the current census of the attack to call lights as therefore the hours staff from the assisted the waiver and this is how staffed for "years." On August 9, 2022, nursing home adminursing home staff answer call lights for during the hours of LNHA-F stated nurson the emergency processed the current census including a residents. LNHA-F	of harm a resident's health or cotential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all e: an Assisted Living Facility capacity of 46 residents: with a	0 470			

Minnesota Department of Health

STATE FORM 6899 IPJI11 If continuation sheet 3 of 30

STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30343	B. WING		08/10/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLEV	WOOD COURT ASSIST	TED LIVING 310 7TH S FULDA, M	TREET NE IN 56131			
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	and alerted staff pe systems.	r the panel and aerial				
	(OM)-H stated nurs the assisted living r 10:00 p.m. and 6:00 assisted living stand background studies living facility. OM-H thought of that requistaff, but was award makes sense." The daily posted so through August 13, staff would provide of 10:00 p.m. and 6 The licensee's Staff 1, 2021, and review identified the staffin number of qualified residents' needs 24 week. During the hoursing home direct would respond to a assistance with hear reasonable amount	fing Plan policy dated August yed February 8, 2022, g plan provided an adequate direct-care staff to meet the -hours a day, seven-days a ours of 10:00 p.m 6:00 a.m. t-care staff and licensed staff resident's request for alth or safety needs within a cof time, as provided in , section 144G.41, subdivision .				
		R CORRECTION: Seven (7)				
	days	,				
0 480 SS=F	144G.41 Subd 1 (1) requirements	3) (i) (B) Minimum	0 480			

Minnesota Department of Health

STATE FORM 6899 IPJI11 If continuation sheet 4 of 30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		30343	B. WING		08/	10/2022
	PROVIDER OR SUPPLIER	TED LIVING 310 7	T ADDRESS, CITY, TH STREET NE A, MN 56131	STATE, ZIP CODE		
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0 480	Continued From pa	ge 4	0 480			
	following services to (i) at least three nut available seven day recommended dieta States Department guidelines, including fresh vegetables. T (B) food must be pr	tritious meals daily with sna ys per week, according to the ary allowances in the United of Agriculture (USDA) g seasonal fresh fruit and	cks e I			
	by: Based on observati review, the licenses prepared and serve Food Code. This practice result violation that did no safety but had the p resident's health or widespread scope (or represent a syste or has the potential the residents). The findings include Please refer to the and Beverage Esta dated August 8, 202 Food Code deficient	included document titled, F blishment Inspection Repor 22, for the specific Minneso	ta r ve d all cod t ta			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLEV	VOOD COURT ASSIST	TED LIVING 310 7TH S FULDA, N	STREET NE IN 56131			
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0 810 SS=F	(b) Each assisted I maintain fire safety plans shall include (1) location and n rooms; (2) employee acti a fire or similar eme (3) fire protection residents; and (4) procedures fo evacuation, or relocemergency includin or unusual resident evacuation. (c) Employees of as receive training on plans upon hiring at thereafter. (d) Fire safety and creadily available at (e) Residents who at their own evacuation proper actions to tainclude movement, training shall be maleast once per year (f) Evacuation drills twice per year per sevacuation drill eve the residents is not activation is not required. This MN Requirements as the maleast on a record of the maleast on a re	iving facility shall develop and and evacuation plans. The out are not limited to: umber of resident sleeping ons to be taken in the event of ergency; procedures necessary for resident movement, eation during a fire or similar g the identification of unique needs for movement or esisted living facilities shall the fire safety and evacuation and at least twice per year evacuation plans shall be all times within the facility. Are capable of assisting in a shall be trained on the ke in the event of a fire to evacuation, or relocation. The de available to residents at	0 810			

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 6 of 30 IPJI11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30343	B. WING		08/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
MAPLE	WOOD COURT ASSIS	TED LIVING 310 7TH S FULDA, M	TREET NE IN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 810	evacuation plan wit to provide required training on fire safe the potential to affe visitors. This practice result violation that did not safety but had the president 's health or cause serious injury was issued at a wide problems are pervate failure that has affer a large portion or a serious include: A record review and August 9, 2022, at Director of Mainten and evacuation plate training, and evacual Record review of the indicated that the findicated that the line evacuation plan for provisions. Record review of an indicated that the line employee training of evacuation plan twite wacuation plan twite wacuatio	h required elements and failed employee and resident ty and evacuation. This had ct all staff, residents, and ed in a level two violation (a tharm a resident's health or octential to have harmed a rafety, but was not likely to y, impairment, or death), and lespread scope (when sive or represent a systemic cted or has potential to affect I of the residents). In the dinterview were conducted on approximately 10:30 a.m. with ance (DM)-G on the fire safety in, fire safety and evacuation ation drills for the facility. The available documentation resafety and evacuation plan cedures for resident tion, and relocation during a	0 810			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30343	B. WING	<u></u>	08/1	0/2022
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 810	Continued From pa	ige 7	0 810			
	employees and could not provide documentation or a policy on employee training of the fire safety and evacuation plan.					
	indicated that the lie training to residents evacuation on the p event of a fire to indo or relocation as req interview, DM-G sta the frequency of tra not provide docume	ne available documentation censee did not provide annual so who can assist in their own proper actions to take in the clude movement, evacuation, juired by statute. During ated that they could not verify alining of residents and could centation or a policy on resident afety and evacuation plan.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
01290 SS=I		on 1 Background studies	01290			
	scheduled voluntees the background sturn 144.057 and may be 245C. Nothing in the construed to prohibe self-disclosure of construed to prohibe section 13.02, subsection 14.02, subsection 14.02, subsection 15.02, s	atractors, and regularly ers of the facility are subject to dy required by section the disqualified under chapter is subdivision shall be subdivision shall be subdivision information. Inder this subdivision shall be the data on individuals under division 12. In employee in good faith tion or records obtained under the assisted living facility to civil r unemployment benefits.				
	by:					

			(X3) DATE COMP	SURVEY LETED		
		30343	B. WING		08/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
MAPLEV	VOOD COURT ASSIS	I EI) I IVIN(÷	STREET NE MN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01290	Based on observat review, the licenses studies were conduservices for one of personnel (ULP)-C had the potential to receiving services. correction order on a.m. In addition, the license was affiliation with the ansisting in cares from the finding serious or a violation that harmonot including serious or a violation that harmonot including serious or a violation that has affected or has portion or all of the The findings included ULP-C had a hire of ULP-C's employee Registry Results For May 12, 2022, from Human Services (Elevidence of a back On August 9, 2022 observed administer froom.	ion, interview and record e failed to ensure background ucted prior to staff providing three employees (unlicensed) with records reviewed. This affect all residents currently This resulted in an immediate August 10, 2022, at 11:08 use failed to ensure a was submitted and received in ussisted living license for staff from the attached nursing with records reviewed. used in a level three violation (a used a resident's health or safety us injury, impairment, or death, as the potential to lead to airment, or death) and was read scope (when problems present a systemic failure that a potential to affect a large residents).				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30343	B. WING		08/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLEV	VOOD COURT ASSIS	TED LIVING 310 7TH S FULDA, M	STREET NE IN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01290	(OM)-H confirmed of for her background completed the finger stated ULP-C had in the finger printing, it is completed the finger printing, it is completed the finger printing, it is completed by OM-H confirmed had background check after ULP-C's file with directed by OM-H to today (August 10, 20 process was to kee studies on her desk through. During the study process, OM-a period of time due had "fallen through." The licensee's 4.02 dated August 1, 202 may provide direct independent direct acceptable result of been received. [The individuals whose mindicate disqualificate. No further information of the immediacy was surveyors' on-site of evaluation supervisions were, noncomposeverity of I (level 3).	ULP-C had not been cleared study as she had not erprinting process. OM-H indicated she had completed out there was no record of it. aving resubmitted the request on August 9, 2022, as requested. ULP-C was a complete finger printing 2022). OM-H indicated her up the incomplete background a until the clearance came at time of ULP-C's background and worked from home for a to Covid-19 and this study the cracks." Background Studies policy 21, included: No employee services and have contact with any residents until f the background study have e licensee] will not employ esults of the background study ation for the position. CORRECTION: IMMEDIATE is removed as confirmed by the observation and review by the or on August 10, 2022; liance remains at a scope and	01290			

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		30343	B. WING 08		08/1	0/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MAPLEV	VOOD COURT ASSIS	TED LIVING 310 7TH S FULDA, N	STREET NE IN 56131				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE		
01290	•	nge 10 STAFF AFFILIATION	01290				
	2022, at 11:30 a.m. between the hours staff from the attac to call lights as the duty for the assiste LALD-A stated the	e conference on August 8, LALD-A and RN-B stated of 10:00 p.m. to 6:00 a.m. hed nursing home responded re was no staff specifically on d living facility during the night. facility did not have a staffing how the facility had been					
	On August 10, 2022, at 8:50 a.m. OM-H confirmed staff assisting with cares between the hours of 10:00 p.m. and 6:00 a.m. from the attached nursing home did not have background studies that were "affiliated," but rather under the nursing home license. OM-H indicated she had not thought of that requirement for the nursing home staff, but was aware of the requirement, stating "it makes sense."						
	No further informat	ion was provided.					
	TIME PERIOD FOR CORRECTION: Two (2) days						
01370 SS=E	144G.61 Subd. 2 (a unlicensed personr	a) Training and evaluation of า	01370				
	unlicensed personr (1) documentation provided; (2) reports of chang to the supervisor de	mpetency evaluations for all nel must include the following: requirements for all services ges in the resident's condition esignated by the facility; control, including blood-borne					

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30343	B. WING	B. WING		10/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREE	ADDRESS, CITY,	STATE, ZIP CODE			
MAPLEV	VOOD COURT ASSIST	TED I IVING	H STREET NE A, MN 56131				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
01370	Continued From pa	ge 11	01370				
	hygiene and groom (i) hair care and bat (ii) care of teeth, gu devices; (iii) care and use of (iv) dressing and as (6) training on the p (7) standby assistant perform them; (8) medication, exereminders; (9) basic nutrition, rand assistance with (10) preparation of licensed health prof (11) communication the dignity of the rethe resident and the cultural background (12) awareness of of (13) understanding between staff and ramily; (14) procedures to emergency situation (15) awareness of of technology equipment This MN Requirement by: Based on observation review, the licensed competency was counlicensed personner.	safe techniques in personal ing, including: thing; ims, and oral prosthetic finearing aids; and esisting with toileting; prevention of falls; ince techniques and how to precise, and treatment in eating; modified diets as ordered by fessional; in skills that include preserving sident and showing respect the resident's preferences, and family; confidentiality and privacy; appropriate boundaries esidents and the resident's use in handling various	y, y a ng for				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		30343	B. WING		08/	10/2022
			STREET NE	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
01370	This practice result violation that did no safety but had the president's health or cause serious injury was issued at a pat limited number of rethan a limited number ituation has occurr found to be pervasion. The findings include ULP-C	ed in a level two violation (a of harm a resident's health or cotential to have harmed a safety, but was not likely to y, impairment, or death) and stern scope (when more than a sesidents are affected, more per of staff are involved, or the red repeatedly; but is not ve).				
	direct care services On August 9, 2022, observed applying deterrent) stockings to increase circulati R2 then performed consisted of taking heart rate and oxyg ULP-C was observe scheduled diuretic of training for the formaintenance of a training on the preworking with the elofalls; communication skidignity of the client	record lacked documentation ollowing topics: quirements for all services clean and safe environment; evention of falls for providers derly or individuals at risk of kills that include preserving the and showing respect for the test of control of the test of				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		30343	B. WING		08/	10/2022	
MAPLEWOOD COURT ASSISTED LIVING 310 7TH S			DDRESS, CITY, S' STREET NE MN 56131	TATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE	
01370	- understanding application and residents ULP-E ULP-E started employee indicate the employ practical skills evaluate following areas: - documentation resproyided; - reports of change supervisor designare maintenance of a hair care and bather care of teeth, gumentation are and use of here designed and assistant perform them; - medication, exerce basic nutrition, meand assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferunderstanding application and assistance with preparation of molicensed health proferu	propriate boundaries between and the resident's family. loyment and began providing ices on May 2, 2022. record lacked evidence to ree completed training and/or uations as required in the quirement for all services in the client's condition to the ted by the facility; clean and safe environment; hing; les, and oral prosthetic devices earing aids; sting with toileting; evention of falls; les techniques and how to lise, and treatment reminders; leal preparation, food safety, in eating; diffied diets as ordered by a fessional; propriate boundaries between and the resident's family; and monly used health technology	;				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		30343	B. WING		08/	10/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	-	
MAPLE	WOOD COURT ASSIS	TED I IVING	STREET NE MN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
01370	training and competed and ULP-E, but had RN-B verified the a ULP-C and ULP-E's. The licensee's 4.05 dated August 1, 202 records would inclu competency testing. The licensee's 5.02 Evaluations policy of identified training an all ULP's would inclued a). Documentation provided b). Reports of chartothe supervisor decorporate and provided b). Appropriate and hygiene and groom i. hair care and ii. care of teed devices iii. care and us iv. dressing and f). Training on the g). Standby assistate perform them h). Medication, exereminders i). Basic nutrition, and assistance with j). Preparation of licensed health provided by the results of the results of the dignity of the results.	tency requirements for ULP-Cd not completed all of them. bove topics were lacking from a employees files. Employee Records policy 21, identified employee ide: verification of completed as required. Competency Training dated August 1, 2021, and competency evaluations follude: requirements for all services in requirements for all services in the resident's condition esignated by the facility control, including blood-borned as afe techniques in personal ing, including: and bathing th, gums, and oral prosthetic in se of hearing aids and assisting with toileting prevention of falls ance techniques and how to the ercise, and treatment in meal preparation, food safety an eating modified diets as ordered by a				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30343	B. WING		08/10/2022	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLEV	VOOD COURT ASSIST	TED I IVING	STREET NE MN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01370	cultural background I) awareness of c m) Understanding between staff and r family n) Procedures to t emergency situation o) Awareness of c technology equipment	I, and family onfidentiality and privacy appropriate boundaries esidents and the resident's use in handling various as commonly used health ent and assistive devices.	01370			
01380 SS=E	unlicensed personn (b) In addition to pa competency evalual providing assisted I (1) observing, reportesident status; (2) basic knowledge changes in body fur observed changes in body fur observed changes appropriate personn (3) reading and record and respirations of (4) recognizing physicand developmental (5) safe transfer tect (6) range of motion (7) administering management (5). This MN Requirements	ragraph (a), training and tion for unlicensed personnel iving services must include: ting, and documenting e of body functioning and actioning, injuries, or other that must be reported to nel; ording temperature, pulse,	01380			

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30343 B. WING	08/10/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
MAPLEWOOD COURT ASSISTED LIVING 310 7TH STREET NE FULDA, MN 56131	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD PROVIDER'S PLAN OF CORRECTION SHOULD PROVIDER'S PLAN OF CORRECTI	D BE COMPLÉTE
ontinued From page 16 review the licensee failed to ensure training and competency evaluations contained all the required training for two of two unlicensed personnel (ULP-C & ULP-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C ULP-C was hired on April 25, 2022, to provide direct care services to residents of the facility. On August 9, 2022, at 8:38 a.m. ULP-C was observed applying TED (thrombo-embollic deterrent) stockings (compression stockings used to increase circulation and reduce blood clots) to R2 then performed a COVID-19 screening which consisted of taking the resident's temperature, heart rate and oxygen saturation. At 1:42 p.m., ULP-C was observed administering R1's scheduled diuretic medication. ULP-C's employee record lacked documentation of training for the following topics: - observation, reporting, and documenting of client status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		30343		B. WING		08/1	0/2022
	PROVIDER OR SUPPLIER	TED LIVING		STREET NE	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE! 'MUST BE PRECEDE! SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER OF THE APPREVIOLENCY)	ULD BE	(X5) COMPLETE DATE
01380	Continued From parappropriate personal recognizing physic developmental need ULP-E ULP-E started employees indicate the employer indicate the employ practical skills evaluated following areas: - observing, reporting status; - basic knowledge of changes in body further observed changes in body further observed changes appropriate personal recognizing physic developmental needers after transfer technical range of motioning ULP-E's employee which listed various transcript lacked evaluation to a competency testing the competency testing the competency testing and competency testing the competency testing the competency testing and competency testing the compet	nel; and cal, emotional, cods of the client dosponent and begoes on May 2, 20 record lacked evice completed trautions as required and document of body functioning, injuries that must be reported and positioning and positioning and positioning record contained training topics; hidence of the above topics were semployees files. Employee Record contained are covered and completed are covered and cover	an providing 022. idence to ining and/or ed in the oting resident ag and so or other orted to organitive, and allation; and the overequired egistered are of the other of them. I acking from ords policy oloyee	01380			

Minnesota Department of Health STATE FORM

STATEMEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		30343	B. WING		08/1	0/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPI FW	OOD COURT ASSIST	TED LIVING 310 7TH S	TREET NE			
WAI EEV	- COD GOOK! AGOIG!	FULDA, M	IN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
01380	Continued From pa	ge 18	01380			
	Evaluations policy of identified training and all ULP's would include. Observing, reported that it is a considerable of the co	perting, and documenting ge of body functioning and enctioning, injuries, or other that must be reported to nel ecording temperature, pulse, the resident eysical, emotional, cognitive, needs of the resident echniques and ambulation ening and positioning medications or treatments as				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
01440 SS=D	144G.62 Subd. 4 S delegated nurs	upervision of staff providing	01440			
	therapy tasks must appropriate licensed registered nurse act facility's policy when provided to verify the performed competer and solutions related to perform the tasks performing medicated administration shall	m delegated nursing or be supervised by an d health professional or a cording to the assisted living re the services are being eat the work is being ently and to identify problems and to the staff person's ability s. Supervision of staff cion or treatment be provided by a registered				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ,	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30343	B. WING		08/1	0/2022
	PROVIDER OR SUPPLIER	310 7TH S	STREET NE	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01440	and must include of administering the minteraction with the (b) The direct super delegated tasks must calendar days after individual begins we performs the delegated requirement also apperformed delegated. This MN Requirement by: Based on observation review, the licensed supervision of staff was provided within date on which the interest the licensee for one (ULP)-C with record. This practice result violation that did not safety but had the president's health or isolated scope (whe residents are affect of staff are involved only occasionally). The findings include ULP-C was hired or direct care services. On August 9, 2022, observed applying deterrent) stockings.	bservation of the staff nedication or treatment and the resident. rvision of staff performing ast be provided within 30 the date on which the pricipal point of the facility and first and tasks for residents and and based on performance. This oplies to staff who have not ed tasks for one year or longer. The performing the facility and first and tasks for one year or longer. The provided within 30 the data tasks for residents and the facility and first and tasks for one year or longer. This opplies to staff who have not entities and record the failed to ensure direct performing delegated tasks and calendar days after the andividual begins working for the of one unlicensed personnel discreviewed. The provided was after the andividual begins working for the of one unlicensed personnel discreviewed. The provided was issued at an an one or a limited number of ed or one or a limited number of ed or one or a limited number all, or the situation has occurred	01440			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30343	B. WING		08/1	0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		-
MAPLEV	VOOD COURT ASSIST	TFD I IVING	STREET NE VIN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01440	Continued From pa	ge 20	01440			
	consisted of taking heart rate and oxyg	a COVID-19 screening which the resident's temperature, en saturation. At 1:42 p.m., ed administering R1's medication.				
	of a RN supervising	record lacked documentation g ULP-C performing a in 30 days of beginning work				
	confirmed ULP-C's	2, at 2:00 p.m. RN-B 30-day supervision of d not been completed as				
	Evaluations policy of include supervision days after the date working for the facil	Competency Training dated August 1, 2021, did not by an RN within 30 calendar on which the individual begins lity and first performs the residents and thereafter as erformance.				
	No further informati	ion was provided.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-One				
01470 SS=F	144G.63 Subd. 2 C	ontent of required orientation	01470			
	topics: (1) an overview of t (2) an introduction a policies and proced	must contain the following his chapter; and review of the facility's lures related to the provision ervices by the individual staff				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 20.2510.			
		30343	B. WING		08/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLEV	VOOD COURT ASSIST	TED I IVING	STREET NE			
	I	FULDA, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILE DEFICIENCY)	D BE	(X5) COMPLETE DATE
01470	Continued From pa	ge 21	01470			
	(3) handling of eme emergency services (4) compliance with maltreatment of vul 626.557 to the Minr Center (MAARC); (5) the assisted livir responsibilities rela and protection of th (6) the principles of and service delivery support services procomplaints, and whincluding information Facility Complaints; (8) consumer advocombudsman for Lo Ombudsman for Moderices, county-mother relevant advocombudsman at the Services, county-mother relevant advocombudsman for Lo Ombudsman for Moderices, county-mother relevant advocombudsman at the Services the employ facility's category of (b) In addition to the orientation may also services to resident training on hearing subdivision must be based, may include include training on topics: (1) an explanation of and how it manifest the challenges it pocousing the challenges it pocousing the challenges it pocousing the challenges it pocousing the policy in the challenges it pocousing	ergencies and use of s; and reporting of the nerable adults under section resota Adult Abuse Reporting and bill of rights and staff ted to ensuring the exercise ose rights; person-centered planning y and how they apply to direct ovided by the staff person; dents' complaints, reporting of ere to report complaints, on on the Office of Health and abilities, Managed Care Department of Human anaged care advocates, or cacy services; and ypes of assisted living yee will be providing and the f licensure. The topics in paragraph (a), to contain training on providing the with hearing loss. Any loss provided under this en high quality and research online training, and must one or more of the following of age-related hearing loss is itself, its prevalence, and sees to communication;				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MDED:	,	E CONSTRUCTION		E SURVEY PLETED	
		30343	В	3. WING		08/	10/2022
	PROVIDER OR SUPPLIER VOOD COURT ASSIS	TED LIVING	STREET ADDR 310 7TH STI FULDA, MN	REET NE	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01470	incidence of demer isolation, and depre (3) information abo that may enhance of involvement, includ assistive listening of and tactile alerting access in real time. This MN Requirements by: Based on interview licensee failed to enfrom the attached of three of three empl (RN)-D, unlicensed ULP-C) received or facility licensing received for providing set. This practice result violation that did not safety but had the president's health or widespread scope or represent a system or has the potential of the residents).	ntia, falls, hospitalizar ession; or ut strategies and teccommunication and ling communication selevices, hearing aids devices, communications, and closed captions ent is not met as evicand record review, the sure staff assisting hursing home of licer oyees (registered numbers onnel (ULP)-E, rientation to assisted quirements and regularvices. The din a level two violes tharm a resident's hospital to have harm safety) and was issued (when problems are emic failure that has to affect a large por	tions, hnology strategies, , visual tion s. denced he in cares isee and rse and living ations ation (a lealth or med a led at a pervasive affected	01470			
	RN-D RN-D was hired on provide assisted liv	September 22, 202	1, to				
	receiving orientation the following required handling of reside	ecord lacked evidendent n to assisted living to ed content: ents' complaints, repo ere to report compla	o include orting of				

Minnesota Department of Health

STATE FORM 6899 IPJI11 If continuation sheet 23 of 30

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30343	B. WING		08/1	0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MADLEV	NOOD COURT ASSIST	STED LIVING 310 7TH S	TREET NE			
WAPLEV	VOOD COURT ASSIS	FULDA, M	IN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01470	including informatic Facility Complaints: - consumer advoca Ombudsman for Lo Ombudsman for Mode Developmental Discombudsman at the Services, county-mother relevant advoca review of the type the employee will be category of licensurate of the principles of processive delivery and support services of this an introduction and policies and processive deliving services and processive deliving service	on on the Office of Health cyservices of the Office of ong-Term Care, Office of ental Health and abilities, Managed Care Department of Human anaged care advocates, or cacy services; ones of assisted living services of eproviding and the facility's re; and erson-centered planning and dinow they apply to direct ovided by the staff person; on May 2, 2022, to provide ices. The record lacked evidence of the to assisted living to include end content: to chapter; of review of the facility's lures related to the provision of ices by the individual staff on the Office of Health cyservices of the Office of the Office, Managed Care Department of Human anaged care advocates, or	01470			
	other relevant advo	cacy services; and ses of assisted living services				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		30343	B. WING		08/1	0/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLEV	VOOD COURT ASSIS	TED LIVING 310 7TH S FULDA, N	STREET NE IN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01470	Continued From pa	age 24	01470			
	the employee will be providing and the facility's category of licensure.					
	ULP-C ULP-C was hired on April 25, 2022, to provide assisted living services.					
	receiving orientation the following requires an overview of thing an introduction are policies and process assisted living services person; I handling of residence complaints, and whice the including information of the consumer advocation of the consumer and the consumer advocation of the c	s chapter; and review of the facility's dures related to the provision of ices by the individual staff ents' complaints, reporting of here to report complaints, on on the Office of Health ; acy services of the Office of ong-Term Care, Office of ental Health and abilities, Managed Care be Department of Human hanaged care advocates, or ocacy services; and oes of assisted living services he providing and the facility's				
	(OM)-H confirmed with cares between 6:00 a.m. had not be orientation. OM-H of that requirement staff, but was awar makes sense."	2, at 8:50 a.m. office manager nursing home staff assisting a the hours of 10:00 p.m. and been trained on assisted living indicated she had not thought for the night nursing home e of the requirement, stating "it				
	On August 10, 202	2, at 2:00 p.m. RN-B				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		30343	B. WING		08/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLEV	VOOD COURT ASSIS	TED LIVING 310 7TH S FULDA, N	STREET NE IN 56131			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
01470	Continued From page 25		01470			
	confirmed the above components of the indicated only piece completed as the li a training in place t RN-B further stated something."	re missing orientation employee files. RN-B es of the orientation had been censee did not currently have hat met all the components. d, "we will need to develop				
	The licensee's 5.01 Orientation of Staff and Supervisor & content policy dated August 1, 2022, noted all staff of [The licensee] providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation must contain the following topics: -an overview of the appropriate assisted living statutes and rules -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff					
	emergency service -compliance wi maltreatment of vu 626.557 to the Mini Center (MAARC) -the assisted liv responsibilities rela and protection of th -principles of p service delivery and support services pr -handling of res of complaints, and including informatic Facility Complaints -consumer adv	th and reporting of the Inerable adults under section nesota Adult Abuse Reporting ving bill of rights and staff sted to ensuring the exercise see those rights. Serson-centered planning and do how they apply to direct rovided by the staff person sidents' complaints, reporting where to report complaints, on on the Office of Health				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30343	B. WING		08/1	0/2022
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLEV	VOOD COURT ASSIST	TED LIVING 310 7TH S FULDA, N	STREET NE IN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01470	Ombudsman for Me Developmental Disa Ombudsman at the Services, county-mother relevant advor-a review of the services the employ facility's category of No further information TIME PERIOD FOR Twenty-One (21) day	ental Health and abilities, Managed Care Department of Human anaged care advocates, or cacy services types of assisted living yee will be providing and the filicensure. on was provided. R CORRECTION:	01470			
01700 SS=D	(a) For each resided management service providing medication a registered nurse, or authorized prescured provided and how the sassessmedication managed provided and how the sassessment must be the same of the s	nt who requests medication res, the facility shall, prior to n management services, have licensed health professional, riber under section 151.37 ment to determine what ement services will be ne services will be provided. The use be conducted face-to-face ne assessment must include different review of all medications the betaking. The review and include indications for ffects, contraindications, reactions, and actions to	01700			

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		30343	B. WING		08/1	0/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
MAPLEV	VOOD COURT ASSIS	TED LIVING 310 7TH S FULDA, M	STREET NE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
01700	manage the resider diversion of medical section, "diversion of theft, or illegal or immedications. This MN Requirements: Based on observative review, the license registered nurse (Remedication manage all required content prior to providing medication that did not safety but had the president's health or cause serious injuried was issued at an is limited number of a limited number of a limited number of situation has occurred. The findings included During the entrance 2022, at approximation confirmed the licen management service receiving assisted Incregular often fast mellitus with diabet with the section of the	entatives on interventions to nt's medications and prevent ations. For purposes of this of medication" means misuse, aproper disposition of medication means misuse, aproper disposition of ment is not met as evidenced from, interview and record a failed to ensure the entate assessment to include a for one of one resident (R1), addication management as reviewed. The disposition of medication (and the harm a resident's health or potential to have harmed a safety, but was not likely to any impairment, or death), and colated scope (when one or a residents are affected or one or a residents are affected or one or a staff are involved or the red only occasionally). The conference on August 8, attely 11:30 a.m., RN-B see provided medication desidents are any of the residents	01700			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		30343			08/1	08/10/2022	
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	TATE, ZIP CODE			
MAPLEV	WOOD COURT ASSIST	TED I IVING	MN 56131				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
01700	Continued From pa	ge 28	01700				
	2022, indicated R1 included medication R1's prescriber ordincluded the following antidepressant, one anti-coagulants, one diuretic medications one anti-angina methest pain). On August 9, 2022, observed unlicense administering R1's R1's record lacked face-to-face review known to be taking side effects, contrained to the management of the management diversion or or others who may medications. On August 9, 2022, R1 had received medications.	agreement dated March 11, received services, which in administration. ers signed March 7, 2022, and medications: one er anti-arrhythmic, two is e insulin injectable, two is, one anti-convulsant, and idication (used as needed for at 1:42 p.m., the surveyor and personnel (ULP)-C ischeduled diuretic medication. evidence the RN conducted a of all medications R1 was to include indications for use, indications, allergic or adverse in the address these issues. In a did not identify interventions agement of medications to finedications by the resident have access to the at 2:16 p.m. RN-C confirmed edication administration admission date on March 11,					
	2022. RN-C further medication manage all the required conbeen performed un March 25, 2022. The licensee's 7.01 Assessment, Monit	r confirmed a face-to-face ement assessment including tent as noted above, had not til R1's 14-day assessment on Medication Management - oring & Reassessment policy					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
		30343	B. WING		08/10/2022						
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DDRESS, CITY, STATE, ZIP CODE								
MAPLEWOOD COURT ASSISTED LIVING 310 7TH STREET NE											
(VA) ID	FULDA, MN 56131										
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE					
01700	Continued From page 29		01700								
	REGULATORY OR LSC IDENTIFYING INFORMATION)										



Type: Full

Date: 08/08/22 Time: 11:00:00 Report: 1033221087

Food and Beverage Establishment Inspection Report

Page 1

-Location:

Maplewood Court Assisted Livng

310 7th Street Ne Fulda, MN56131 Murray County, 51

License Categories:

Expires on: //

Establishment Info:

ID#: 0038942

Risk:

Announced Inspection: No

Operator:

Phone #: 5074252571

ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C3

** Priority 1 **

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

Sanitizer bucket with quaternary ammonium was measured at 50ppm.

Comply By: 08/08/22

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

Cooler gaskets have visible mold build up.

Comply By: 08/08/22

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit

Location: Dish Machine Violation Issued: No

Quaternary Ammonium: = 50 at Degrees Fahrenheit

Location: Sanitizer Bucket Violation Issued: No

Page 2

Type: Full
Date: 08/08/22
Time: 11:00:00
Report: 1033221087

Food and Beverage Establishment Inspection Report

Maplewood Court Assisted Livng

Food and Equipment Temperatures					
Process/Item: Cold Holding Temperature: 39 Degrees Fahrenheit - Location: Cooler Ambient Violation Issued: No					
Process/Item: Cold Holding Temperature: 39 Degrees Fahrenheit - Location: Drink Cooler Violation Issued: No					
Process/Item: Hot Holding Temperature: 170 Degrees Fahrenheit - Location: Fish Fillets-Warmers Violation Issued: No					
Process/Item: Hot Holding Temperature: 160 Degrees Fahrenheit - Location: Ground Beef-Warmer Violation Issued: No					
Total Orders In This Report Priority 1 Priority 2 Priority 3 1 0 1 NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations. I acknowledge receipt of the inspection report number 1033221087 of 08/08/22.					
Certified Food Protection Manager Michele Schettler					
Certification Number: FM111813 Expires: 05/02/25					
Inspection report reviewed with person in charge and emailed.					
Signed: Signed					
507-344-2743 isaiah.armendariz@state.mn.us					