



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 20, 2022

Administrator
Maplewood Manor LLC
1010 1st Street Northeast
Elbow Lake, MN 56531

RE: Project Number(s) SL36368015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 15, 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.

LICENSING ORDERS

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 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

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

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 email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

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. Please note that you may request a reconsideration or a hearing, but not both.

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,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-201-3789 Fax: 651-215-9697

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36368	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2022
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NAME OF PROVIDER OR SUPPLIER MAPLEWOOD MANOR LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 1ST STREET NE ELBOW LAKE, MN 56531
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0 000	<p>Initial Comments</p> <p>Initial comments *****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS: SL36368015</p> <p>On November 14, 2022, through November 15, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were thirty-five (35) residents; twenty (20) residents receiving services under the provider's Assisted Living Dementia Care license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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0 480	<p>Continued From page 1</p> <p>(13) offer to provide or make available at least the following services to residents:</p> <p>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:</p> <p>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all 20 residents in the Assisted Living with Dementia Care facility.</p> <p>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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>Please refer to the included document titled, Food and Beverage Establishment Inspection Report,</p>	0 480		

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0 480	Continued From page 2 dated November 14, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect all staff, residents	0 510		

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0 510	<p>Continued From page 3 and visitors.)</p> <p>The findings include:</p> <p>On November 14, 2022, at 11:48 a.m., the surveyor observed unlicensed personnel (ULP)-B provide medication and treatment administration to R1, which included blood glucose testing and insulin administration. ULP-B did not perform hand hygiene when donning (putting on) and doffing (taking off) gloves.</p> <p>During observation on November 14, 2022, at 11:48 a.m., ULP-B obtained R1's blood glucose meter from the licensee's locked medication cart. ULP-B donned gloves to both hands after obtaining the blood glucose meter. ULP-B did not wash or sanitize hands before donning gloves. ULP-B then left the medication room wearing gloves and entered R1's room. ULP-B explained to R1 that she would be receiving a blood glucose check and asked R1 which finger she would like ULP-B to use. R1 extended her right index finger and with gloved hands, ULP-B removed needle from packaging and placed it onto the needle injector. ULP-B then removed an alcohol wipe from its packaging and wiped R1's right index finger with the wipe. ULP-B allowed R1's finger to dry and placed the needle injector onto right index finger and depressed button, obtaining blood from R1's right index finger. ULP-B wiped the first drop of blood from right index finger using a tissue and squeezed R1's finger to obtain another drop of blood. ULP-B then placed the glucose meter test strip to the drop of blood. ULP placed a tissue over the area that R1's finger was bleeding from. ULP-B placed the test strip into the meter. ULP-B then left R1's room wearing the same gloves and returned to the medication room where she opened the door with a key. R1</p>	0 510		

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0 510	<p>Continued From page 4</p> <p>entered the medication room and opened the medication cart. ULP-B then opened laptop on top of medication cart and with gloved hands documented result of blood glucose testing. ULP-B then doffed gloves, obtained a new pair of gloves and donned them to both hands. ULP-B did not sanitize or wash hands after doffing gloves or before donning a new pair. ULP-B obtained an insulin pen from the medication cart and proceeded to remove the cap and place a needle onto the insulin pen. ULP-B dialed the insulin pen to the dose as prescribed. ULP-B locked the medication cart, left the medication room, closed the door with a gloved hand, had another staff member verify the dose of insulin, proceeded to return to R1's room. ULP-B obtained an alcohol wipe from its package, wiped an area on R1's stomach, verified dose of insulin on pen, placed the needle into abdomen, and depressed the button on insulin pen. ULP-B asked R1 if they needed anything else and after response, left the room wearing gloves on both hands and returned to the medication room. ULP-B unlocked the door with a key while wearing the same gloves. Upon entering the medication room, ULP-B unlocked the medication cart, placed insulin needle in sharps container, returned capped insulin pen into the medication cart, opened laptop, and documented administration of insulin. ULP-B then doffed gloves. ULP-B did not sanitize or wash hands after doffing gloves.</p> <p>On November 14, 2022, at 12:20 p.m., registered nurse (RN)-A was notified of ULP-B not performing hand hygiene before or after application of donning or doffing gloves. RN-D stated all ULPs had been trained and instructed to wash hands by RN-A.</p>	0 510		

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0 510	Continued From page 5 The licensee's Handwashing policy dated January 20, 2020, indicated handwashing would be performed before and after any gloving. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with	0 650		

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0 650	<p>Continued From page 6</p> <p>the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included an annual performance review for one of two employees (registered nurse (RN)-A).</p> <p>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 an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>RN-A had a hire date of January 3, 2021. RN-A's employee record lacked evidence an annual performance review was completed.</p> <p>On November 15, 2022, at 1:18 p.m., RN-A stated she had not received an annual performance review since she had been employed by the licensee.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	0 650		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	<p>Continued From page 7</p> <p>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>(1) for dwellings or sleeping units, as defined in the State Fire Code:</p> <p>(i) provide smoke alarms in each room used for sleeping purposes;</p> <p>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;</p> <p>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;</p> <p>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and</p> <p>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that were interconnected in some resident's apartments. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected</p>	0 780		

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0 780	<p>Continued From page 8</p> <p>or has the potential to affect a large portion or all residents).</p> <p>The findings include:</p> <p>On November 16, 2022, between 10:20 a.m. and 11:50 a.m., survey staff toured the facility with Registered Nurse (RN)-A and Maintenance Director (MD)-D. During the facility tour, survey staff observed that there were no smoke alarms in the resident bedroom's in all of the apartments on the independent care wing. Survey staff was unable to verify that the smoke alarms in these resident apartments were interconnected so that actuation of one alarm caused all alarms in the dwelling to actuate.</p> <p>RN-A and MD-D verbally confirmed survey staff observations during the facility tour.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 780		
0 970 SS=C	<p>144.50 Subd. 5 Waivers of liability prohibited</p> <p>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.</p> <p>This MN Requirement is not met as evidenced by:</p>	0 970		

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0 970	<p>Continued From page 9</p> <p>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for the health, safety, or personal property of a resident for one of one resident (R1).</p> <p>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>R1 was admitted on July 13, 2022.</p> <p>R1's Housing with Services Contract & Lease Agreement was signed on July 13, 2022. R1's Housing with Services Contract & Lease Agreement included a clause that indicated the licensee was not responsible for any damage or injury suffered by residents or to residents' property that was not caused by licensee. The agreements indicated the licensee strongly recommended that residents obtain renter's insurance at an appropriate level to insure against loss of personal property, as well as related incidental and consequential damages, or such other or additional insurance as resident considers necessary to protect against injuries and property damage as the licensee indicated their insurance may not cover the loss of personal property and the incidental and consequential damages arising from the loss of such property. The agreements indicated residents' personal property included but was not limited to dentures,</p>	0 970		

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0 970	Continued From page 10 glasses, and hearing aids. On November 15, 2022, at 10:50 a.m., licensed assisted living director (LALD)-C stated all the licensee's resident agreements contained liability wavier language as indicated above and LALD-C believed that the wording in the lease agreement/resident contract was correct. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff 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 may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living licensing requirements and regulations before providing services for one of two employees (unlicensed personnel (ULP)-B). 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	01460		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36368	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/15/2022
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NAME OF PROVIDER OR SUPPLIER MAPLEWOOD MANOR LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 1ST STREET NE ELBOW LAKE, MN 56531
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01460	<p>Continued From page 11</p> <p>resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>ULP-B began providing direct care services to residents on August 12, 2022. ULP-B provided services to residents include medication administration, activities of daily living, and meals.</p> <p>ULP-B's record lacked documentation of the overview of assisted living statutes, a review of the licensee's policies and procedures related to the provision of assisted living services, and principles of person-centered planning and service delivery.</p> <p>On November 14, 2022, at 2:30 p.m., registered nurse (RN)-A verified the lack of employee training records for ULP-B. RN-A stated they were unable to verify ULP-B's orientation to the assisted living licensing requirements and regulations.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01460		
01880 SS=F	<p>144G.71 Subd. 19 Storage of medications</p> <p>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.</p>	01880		

Minnesota Department of Health

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01880	<p>Continued From page 12</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to store all prescription medications according to the manufacturer's directions for one of two residents (R1).</p> <p>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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R1 had diagnoses to include dementia and diabetes.</p> <p>R1's medication and treatment administration record dated November 2022, indicated staff were administering insulin up to three times per day to R1.</p> <p>On November 14, 2021, at 12:17 p.m., unlicensed personnel (ULP)-B was observed to administer 12 units of insulin via NovoLog FlexPen 100 unit/ml to R1.</p> <p>On November 14, 2021 at approximately 12:10 p.m., ULP-B was asked to indicate where the licensee's medication refrigerator was located. ULP-B escorted the surveyor to the medication room where there was a dorm size refrigerator and separate dorm size freezer. Inside the refrigerator were three boxes of NovoLog</p>	01880		

Minnesota Department of Health

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01880	<p>Continued From page 13</p> <p>FlexPens. The surveyor noted a thermometer located on the first rack of the refrigerator. The thermometer reading was 48 degrees Fahrenheit. When asked if there was a thermometer, ULP-B could not locate one but stated she would look into where it would be. The freezer door was noted to be ajar and unable to close due to accumulation of ice on the freezer walls. The surveyor did not observe a thermometer located in the freezer.</p> <p>NovoLog prescribing information dated November 2021, indicated FlexPens should be kept between thirty-six (36) degrees Fahrenheit and forty-six (46) degrees Fahrenheit when not punctured.</p> <p>At approximately 1:25 p.m., the surveyor requested licensed assisted living director (LALD)-C view findings of medication refrigerator. LALD-C stated they had recently changed the refrigerator as the previous refrigerator was not working. LALD-C was not aware of the temperature readings or of the ice accumulation causing the freezer door to remain ajar.</p> <p>The licensee's Storage of Medications policy dated October 1, 2018, indicated medications would be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen).</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01880		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy	01950		

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01950	<p>Continued From page 14</p> <p>Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:</p> <ol style="list-style-type: none"> (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) trained and verified competency with treatments and therapies for one of one employee (unlicensed personnel (ULP)-B).</p> <p>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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p>	01950		

Minnesota Department of Health

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01950	<p>Continued From page 15</p> <p>The findings include:</p> <p>R1 was admitted on July 13, 2022, and had diagnoses of dementia and diabetes.</p> <p>R1's Individualized Treatment and Therapy Plan dated July 15, 2022, indicated R1 received wound care treatment to an open pressure wound on the left buttock. This treatment was completed by ULPs as delegated by RN-A.</p> <p>ULP-B was hired on August 12, 2022, to provide direct cares to licensee's residents.</p> <p>ULP-B's employee record lacked documentation ULP-B was trained and demonstrated competency to a RN to perform the specific wound care treatment to R1.</p> <p>On November 14, 2022, at 2:18 p.m., RN-A confirmed ULP-B's personnel file did not contain documentation ULP-B had been trained or deemed competent by the RN to provide a prescribed wound treatment to R1. RN-A stated she had trained ULP-B to perform the wound treatment and observed ULP-B completing the treatment as prescribed. RN-A stated she did not document this delegated training or competency testing.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01950		
02040 SS=F	<p>144G.81 Subdivision 1 Fire protection and physical environment</p> <p>An assisted living facility with dementia care that</p>	02040		

Minnesota Department of Health

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02040	<p>Continued From page 16</p> <p>has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents).</p> <p>The findings include:</p> <p>A review of the Hazard Vulnerability Assessment showed global hazards such as fire, gas leaks, and epidemics but did not include hazards or safety risks identified on and around the property.</p> <p>During an interview on November 16, 2022, at 11:50 a.m., the Registered Nurse (RN)-A confirmed during an interview that the facility failed to include safety risks or hazards identified</p>	02040		

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02040	Continued From page 17 on and around the property in the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		



MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: 11/14/22
Time: 14:21:34
Report: 7935221283

Food and Beverage Establishment Inspection Report

Page 1

Location:

Maplewood Manor Llc
1010 1st Street Ne
Elbow Lake, MN56531
Grant County, 26

Establishment Info:

ID #: 0038006
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2186853600
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.

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12G

MN Rule 4626.0275G Store the bulk food dispensing utensil in the food with the handle extending out of the food, or in a protective enclosure attached or adjacent to the enclosure with the utensil on a tether of easily cleanable material which is short enough to prevent the utensil from making contact with the floor.

HANDLE WAS LAYING DOWN IN BULK SUGAR BIN. EMPLOYEE MOVED SCOOP SO HANDLE WAS STICKING OUT OF SUGAR.

Corrected on Site

4-500 Equipment Maintenance and Operation

4-502.13MN

MN Rule 4626.0833 Cut bulk milk dispensing tubes on the diagonal, leaving no more than one inch protruding from the chilled dispensing head.

REMOVE PLASTIC PROTECTIVE COVERING FROM TUBE, AND CUT APPROPRIATELY. TUBE WAS TOO LONG AND CUT STRAIGHT.

Comply By: 11/14/22

6-200 Physical Facility Design and Construction

6-202.14

MN Rule 4626.1390 Provide necessary walls and ceiling to completely enclose toilet rooms and a tight-fitting, self-closing device on the toilet room door.

EMPLOYEE BATHROOM DOOR NEEDS SELF CLOSING DEVICE.

Comply By: 11/14/22

Surface and Equipment Sanitizers

Type: Full
Date: 11/14/22
Time: 14:21:34
Report: 7935221283
Maplewood Manor Llc

Food and Beverage Establishment Inspection Report

Hot Water: = at 176 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Three Comp Sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: Hoshizaki Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: Walk In
Violation Issued: No

Process/Item: Cooking
Temperature: 176 Degrees Fahrenheit - Location: Country Fried Steak
Violation Issued: No

Process/Item: Hot Holding
Temperature: 150 Degrees Fahrenheit - Location: Corn
Violation Issued: No

Process/Item: Hot Holding
Temperature: 155 Degrees Fahrenheit - Location: Gravy
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	0	3

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MN Department of Health inspection report number 7935221283 of 11/14/22.

Certified Food Protection Manager: Patricia Welcome

Certification Number: 110213 Expires: 02/24/25

Signed: _____
Establishment Representative

Signed: 7935
7935

651-201-4500
health.foodlodging@state.mn.us