Electronically Delivered

April 3, 2025

Licensee
Maple Woods Assisted Living
40170 County Road 257
Cohasset, MN 55721

RE: Project Number(s) SL30666016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 5, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted 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(s) 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 MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30666	A. BUILDING: _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. 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. INITIAL COMMENTS: SL30666016 On February 3, 2025, 2024, through February 5, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 14 residents receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been 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 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 evaluators ' findings is the Time Period for Correction. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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 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 is 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 of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 3, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure weekly menus were made available to the residents. This had the potential to affect all 14 residents. 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 potential to affect a large portion or all of the residents). The findings include:	0 485		

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0 485	Continued From page 4 During the entrance conference on February 3, 2025, at approximately 10:15 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C stated the licensee provided three meals daily to include fresh fruits and vegetables, snacks were offered, residents had input with menus, and residents were made aware of changes to the menu. During a tour of the facility on February 3, 2025, at approximately 11:00 a.m., with LALD-A and CNS-C, LALD-A stated the facility consisted of two houses, House A and House B. The two houses were joined by a commons area. In both houses the surveyor observed a single-day menu written on a white board near each kitchen. CNS-C reached on top of the refrigerators in House B and House A and produced a menu for the week. Directly after the above observation CNS-C stated the weekly menu was not normally given to the residents or accessible to the residents. CNS-C stated if a resident were to ask for a menu the resident would be given a weekly menu. LALD-A stated weekly menus used to be posted in each house, but confirmed weekly menus were not currently available to the licensee's residents. The licensee's Menu Planning policy dated February 19, 2023, noted menus would be prepared at least one week in advance and made available to guests at least one week in advance. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		

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0 510 SS=D	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 ensure infection control standards were followed by one of three unlicensed personnel (ULP-D) while providing direct care to one of one resident (R6). 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 residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-D was hired on December 31, 2024, to provide direct care services to the facility's residents.	0 510		

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0 510	Continued From page 6 ULP-D's employee record indicated ULP-D had received competency training to include infection control on January 2, 2025. On February 4, 2025, from 6:57 a.m., through 7:23 a.m., the surveyor continuously observed ULP-D. -at 6:57 a.m., the surveyor observed R6 sitting on the toilet in R6's room. The surveyor observed ULP-D apply a gait belt around R6's waist. ULP-D stated he needed to grab a pair of gloves. ULP-D said, these gloves won't fit (gloves found in R6's bathroom). The surveyor observed ULP-D ask R6 if he could check R6's brief. ULP-D checked R6's brief barehanded. ULP-D got a clean brief for R6 and placed the clean brief on the floor of R6's bathroom, near the toilet. ULP-D placed a new trash liner into a trash can positioned near the toilet in R6's room. With un-gloved hands ULP-D started to tear R6's wet brief off. -at 6:59 a.m., ULP-H knocked on R6's door. ULP-D asked ULP-H for a pair of large or extra-large gloves. ULP-D told R6 that he needed to pull the brief down a little so he could "rip" the brief off. ULP-D removed R6's wet brief, shoes, and pants. -at 7:01 a.m., ULP-D went to the door and called for ULP-H and there was no answer from ULP-H. ULP-D asked R6 if she would like a different shirt to wear. ULP-D moved the clean brief from the floor and placed the brief behind a grab bar positioned on the wall near the toilet. ULP-D removed the gait belt around R6's waist. ULP-D removed the shirt R6 had on. R6 stated she would like a long-sleeved shirt to wear. -at 7:06 a.m., ULP-D picked out a long-sleeved shirt for R6. ULP-D dressed R6 in the	0 510		

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0 510	Continued From page 7 long-sleeved shirt. ULP-D put a clean brief and pants on R6's lower body when R6 was seated on the toilet. ULP-D applied shoes to R6's feet. ULP-D applied a gait belt around R6's waist. -7:14 a.m., ULP-D told R6 that he was going to stand her up (R6). ULP-D pulled R6's brief up and pants up, while R6 held onto the grab bar near the toilet. ULP-D assisted R6 into a wheelchair positioned near the bathroom door. ULP-D removed R6's shoes. ULP-D moved the wheelchair to R6's bedside and assisted R6 into bed. ULP-D placed R6's shoes under R6's bed per R6's request. ULP-D exited R6's room. -7:19 a.m., the surveyor observed ULP-D go to the nurse's room, which was down the hallway. ULP-D handed ULP-F a pager. ULP-D went to the medication cart and performed a narcotic count with ULP-G. The surveyor did not observe ULP-D perform hand hygiene after toileting, dressing, and transferring R6 and prior to handing off the pager or performing a narcotic count. -7:23 a.m., ULP-D stated he should not have placed a clean brief on the floor, adding he "tries" to put a clean brief up between the grab bars. ULP-D stated he should have washed his hands during and after caring for R6. On February 4, 2025, at 10:16 a.m., clinical nurse supervisor (CNS)-C stated clean briefs should not be placed on the floor. In addition, CNS-C stated hands should be washed after gloves were removed. CNS-C stated hands should be washed if gloves were used or not used. The licensee's Hand Hygiene policy dated November 7, 2024, noted hand washing shall be performed between resident cares and whenever	0 510		

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0 510	Continued From page 8 direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: -before and after direct contact with a resident -if moving from a contaminated-body site to a clean-body site during resident care -after contact with environmental surfaces or equipment in the immediate vicinity of the resident -after removing gloves or gowns -before eating and after using a restroom. The licensee's Standard (Universal) Precautions for Infection Control policy dated November 7, 2024, noted hand washing was crucial. Staff would wash hands: -after touching blood, body fluids, feces, or contaminated items (regardless of whether or not gloves were worn) -as necessary, between tasks and procedures on the same resident to prevent cross-contamination of different body sites, and between all patient contacts. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680		

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0 680	Continued From page 9 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content and failed to post an EPP prominently. This had the potential to affect all residents, staff, 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, but was not likely to cause serious injury, impairment, or death), and is 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 of the residents). The findings include:	0 680		

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0 680	Continued From page 10 During the entrance conference on February 3, 2025, at 10:31 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C, LALD-A stated the facility had two EPPs. LALD-A stated each "unit" (house/ House A, House B) had an EPP. LALD-A stated the EPP for House B was next to the computer in a cupboard that was never locked. On February 3, 2025, at approximately 11:30 a.m., during a tour of the facility with LALD-A and CNS-A, the surveyor did not observe any signage of the facility's EPP, in either House A or House B. On February 3, 2025, at 11:42 a.m. LALD-A went to the cupboard in House B to locate the EPP. LALD-B stated the EPP was not in the cupboard. LALD-A stated there was no signage for the location of facility EPP in House B or in House A. In addition, LALD-A did not find an EPP in House A. LALD-A did locate the EPP in the office in House B. LALD-A stated the office door was locked when unoccupied. The facility's EPP risk assessment was dated April 15, 2022. The licensee's EPP, dated April 15, 2022, lacked the following content and/or policies and procedures to address: - a description of the population served by the licensee - transportation - agreements with other facilities. On February 5, 2025, at 10:51 a.m., the EPP binder was reviewed with LALD-A. LALD-A stated the facility's EPP was discussed during QM	0 680		

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0 680	Continued From page 11 (quality management) however LALD-A stated the facility's EPP did not reflect any of the QM discussion. LALD-A stated the risk assessment had not been updated. LALD-A stated transportation was not addressed, and the description of the population served was not in the EPP. LALD-A stated the licensee had a "sister site," however there was not an agreement with the sister site or any other location in the EPP. In addition, LALD-A stated the EPP's location was not posted and the EPP was not where staff was told the EPP was located. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. The licensee's Emergency and Disaster Preparedness policy dated February 19, 2023, noted a hazard vulnerability assessment had been completed to identify the most probable emergency situations that may be experienced by this facility or community. An assisted living facility with dementia care that had a secured dementia care unit must include in their hazard vulnerability assessment a 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. The EPP addresses the following	0 680		

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	30666	A. BUILDING: _____ B. WING _____	02/05/2025

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0 680	Continued From page 12 requirements: -addresses our resident population, including, but not limited to, person at risk: the type of services the facility has the ability to provide in an emergency; and continuity of operation, including delegations of authority and succession plans -the emergency plan contains a plan of evacuation, addresses elements of sheltering place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency. The emergency operations plan, communications plan, and the policies and procedures listed above will be reviewed and updated at least annually. In addition, the facility would post the emergency disaster plan prominently. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, 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	0 775		

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0 775	Continued From page 13 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 of the residents). Findings include: On a facility tour on February 3, 2025, from 1:00 p.m. to 3:35 p.m., with agent/ owner (A/O)-D, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: SMOKE ALARM MAINTENANCE The smoke alarms in the corridor of buildings A, B, and C, were removed by AD/O-D, in order to check manufacture date. The smoke alarms in the corridor of building A indicated a manufacture date of 2008, building B indicated a manufacture date of 2010, and building C indicated a manufacture date of 2012. Smoke alarms are required to be maintained with a manufacture date of not more than 10 years from date of manufacture. CARBON MONOXIDE ALARMS There was not carbon monoxide alarms observed outside and within ten feet of all resident sleeping rooms. Carbon monoxide alarms are required to be installed outside and within ten feet of all sleeping rooms. EXTERIOR EXIT PATH MAINTENANCE	0 775		

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0 775	Continued From page 14 The marked exterior exit doors leading to the back fenced area from the two resident lounge areas in building B were not maintained clear of snow as an obstruction in the exterior exit path to the public way (parking lot, sidewalk, driveway). Exterior exit paths are required to be maintained clear of snow and obstructions that prevent full and immediate access to the exit path leading to the public way. OXYGEN CYLINDER STORAGE There was an oxygen tank observed not secured with a chain or rack to maintain in the upright position in resident sleeping room ten in building B. Oxygen cylinders are required to be secured in the upright position. DOOR LOCKING The only doorway out of the commercial kitchen was provided with hardware and a padlock on the outside non-egress side of the door. All spaces within the building are required to be provided with hardware and locking arrangements that are openable from the inside egress side for exiting in the event of a fire or similar emergency. FIRE SPRINKLER SYSTEM MONITORING During the tour A/O-D, stated the fire sprinkler system was not electronically monitored by a central monitoring station to automatically notify the fire department in the event of fire sprinkler	0 775		

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0 775	Continued From page 15 activation. Existing fire sprinkler systems with 100 or more sprinkler heads on the system are required to be electronically monitored to automatically notify the fire department upon activation of the fire sprinkler system. COMMERCIAL KITCHEN VENTILATION HOOD AND DUCT CLEANING There was not documentation available indicating the commercial kitchen ventilation hood and duct system was cleaned as required. Commercial kitchen ventilation hood and duct systems are required to be cleaned and maintained semi-annually. During the facility tour A/O-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;	0 780		

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0 780	Continued From page 16 (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 (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; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, 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 a large portion or all of the residents). Findings include: SMOKE ALARM INTERCONNECTION On a facility tour on February 3, 2025, from 1:00 p.m. to 3:35 p.m., with agent/ owner (AD/O)-D, it was observed that smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility.	0 780		

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0 780	Continued From page 17 All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. The smoke alarms in buildings A, B, and C are all required to be interconnected so activation of one alarm activates all alarms in all three buildings. The facility is considered one dwelling unit. During the tour the smoke alarms were tested and A/O-D, verified the smoke alarms were not interconnected so activation of one alarm activates all alarms throughout the facility. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient	0 790		

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0 790	Continued From page 18 condition had the ability to affect all staff, visitors, and residents. 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). The findings include: On a facility tour on February 3, 2025, from 1:00 p.m. to 3:35 p.m., with agent/ owner (A/O)-D, it was observed that the required class K fire extinguisher in the commercial kitchen was sitting on the floor and not mounted on wall as required. At least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During the tour A/O-D, verified the above listed observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		

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0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, 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, 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). The findings include: On a facility tour on February 3, 2025, from 1:00 p.m. to 3:35 p.m., with agent/ owner (A/O)-D, the surveyor made the following observations of facility disrepair: There was a missing light fixture exposing the	0 800		

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0 800	Continued From page 20 electrical wires in the closet of resident sleeping room one in the A building. The bathroom exhaust fans were not working when the switch was turned on in the bathrooms of resident sleeping units one and nine. The fiberglass base of the shower was broken with a hole through the surface in the shower of resident sleeping unit nine. The ceiling was damaged by water and drywall was missing in the mechanical room of the C building. During the tour A/O-D, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive	0 810		

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0 810	Continued From page 21 training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, 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 potential to affect a large portion or all of the residents). The findings include: On February 3, 2025, at 12:15 p.m., licensed assisted living director (LALD)-A, provided	0 810		

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0 810	Continued From page 22 documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP undated, failed to include the following: The available FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on February 3, 2025, at 1:20 p.m., LALD-A, stated the resident evacuation status/ unique needs for each resident was not available in writing for immediate use. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire as evident by providing documentation the employees were trained twice a year along with fire evacuation drills. Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the	0 810		

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0 810	Continued From page 23 residents were providing training as required. During an interview on February 3, 2025, at 1:15 p.m., LALD-A, stated the documentation for training completed by employees at hire and training provided to residents was not available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.	01060		

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01060	Continued From page 24 (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of two residents (R2). 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 residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included schizophrenia (chronic brain disorder, combination of hallucinations, delusions, and disordered thinking and behavior).	01060		

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01060	Continued From page 25 R2's service plan dated February 3, 2025, indicated R2 received medication administration, ACE wraps (compression bandage in a long strip of stretchable cloth), dressing, grooming, toileting, ambulation assistance, and housekeeping services. Progress notes for R2 included: -dated January 27, 2025: sitting in recliner (R2) pale, tired, weak. Vital signs 93/50 (blood pressure), 73 (pulse), 97% (oxygen level), 16 (respirations). No shortness of breath does have dyspnea (difficulty breathing) with exertion. Negative for COVID today. Saturday, and last Thursday the 23, was positive previous to that (COVID). She (R2) has been having increased diarrhea up five to seven per day. Not eating more than 500 calories past five days. Skin has begun breaking down on bottom. Will update PCP (primary care provider). Attempt to set up appointment with (name of clinic/hospital) and they do not have any appointments that we can set up transport for her. Called daughter and she would like her (R2) sent into ED (emergency department) for evaluation. Call out to emergency services for transport. -dated January 31, 2025: spoke to RN (hospital, registered nurse) reports resident is doing much better today. Started on heparin drip due to sustained A-Fib. (atrial fibrillation/ an irregular and often very rapid heart rhythm that can lead to blood clots in the heart). Physical therapy and occupational therapy working with her for strengthening. Alert to self and place. Aware of month but not date. Will step down today to medical from ICU (intensive care unit). Will update licensee on Monday. -Emergency Relocation Notification: dated February 3, 2025, eight days from relocation from	01060		

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	30666	A. BUILDING: _____ B. WING _____	02/05/2025

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MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

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01060	Continued From page 26 facility. On February 3, 2025, at 11:58 a.m., clinical nurse supervisor (CNS)-C stated she wrote a note, completed the form for relocation, in R2's record however she did not send the notice to anyone. R2's record lacked a written notice that contained, at a minimum: - record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date is not currently known. - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On February 4, 2025, at 1:03 p.m., CNS-C stated she really "screwed that up" (R2's relocation form). CNS-C said she updated R2's daughter a couple of times, and R2's doctor of R2's status. CNS-C stated she was not sure if R2's case manager had been updated about R2's relocation, as LALD-A or office manager/unlicensed personnel (OM/ULP)-I usually did that (updated case managers). CNS-C left the room, and returned to the room the surveyor was located in and stated "they" (LALD-A or OM/ULP-I) was going to do that (contact case manager) "right now". CNS-C stated she wrote a note in R2's record, but did not do anything with it. CNS-C added she was just learning the process. CNS-C added she had watched LALD-A complete the required	01060		

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01060	Continued From page 27 notification for another resident who had been out of the facility for greater than four days. The licensee's Discharge and Transfer of Residents policy dated July 20, 2021, noted in the event of an emergency relocation, the facility would, as soon as possible, provide written notice of Emergency Relocation the following: -the resident -the resident's legal representative -the resident's designated representative -if the resident received home and community-based services, the resident's case manger -if the resident had been relocated and not returned to the (name of licensee) within four days the Office of Ombudsman for Long-Term Care. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01560 SS=D	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery.	01560		

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01560	Continued From page 28 (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure dementia training included all the required content for one of two employees (clinical nurse supervisor (CNS)-C). 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 residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: CNS-C was hired on October 31, 2024, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On February 3, 2025, at 10:07 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated CNS-C was the CNS for the facility. On February 4, 2025, at approximately 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-G hand CNS-C an empty seven-day medication planner from the locked medication	01560		

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01560	Continued From page 29 cart for R4. CNS-C's record included: - dementia, problem solving- anger and aggression, dated November 8, 2024, (0.5 hour/ thirty minutes) - dementia, activities, toileting, dated November 8, 2024, (0.5 hour) - dementia, problem solving, sleep problems and sundowning, dated November 8, 2024, (0.5 hour) - dementia problem solving, wandering and elopement, dated November 8, 2024, (0.75 hour, forty-five minutes) - dementia, problem solving, use of medication, dated November 8, 2024, (0.75 hour) - dementia 1, introduction and overview, dated November 8, 2024, (1 hour/sixty minutes) - dementia 2, communication, dated November 8, 2024, (1.25 hour/seventy-five minutes) - dementia 3, activities of daily living dated November 8, 2024, (1 hour) - dementia 4, behaviors vs symptoms, dated November 8, 2024, (1 hour) - dementia 5, the journey, dated November 8, 2024, (0.75 hour). CNS-C's record did not include person-centered planning and service delivery. On February 4, 2025, at 12:30 p.m., CNS- C stated she had completed eight hours of dementia training. The surveyor reviewed CNS-C's employee record with office manager/ unlicensed personnel (OM/ULP)-I. OM/ULP-I stated person centered training did not get activated for some reason. OM/ULP-I added she saw the required training on the system used but confirmed CNS-C had not completed the training as required.	01560		

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01560	Continued From page 30 The licensee's Staff Orientation and Education policy dated July 20, 2021, noted all staff providing assisted living through (name of licensee) would be prepared to provide safe, effective services to all residents through a thorough orientation and education program pertinent to the needs of the residents. Upon hire and before providing service to residents, all employees attend a general orientation conducted by (licensee). The policy included, all direct care staff and supervisors providing direct services must receive training on dementia. The licensee's Assisted Living with Memory Care-Dementia Training policy dated May 2, 2022, noted dementia care training would include person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman	01640		

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01640	Continued From page 31 for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure service plans were revised to reflect the current services provided for one of three residents (R7). 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 residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R7's diagnosis included peptic ulcer disease and gastroesophageal reflux disease (GERD- where stomach content persistently and regularly flows up into the esophagus). R7's service plan effective date November 28, 2024, authenticated January 8, 2025, by resident, and January 21, 2025, by facility representative, included medication administration. R7's service plan did not include medication	01640		

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01640	Continued From page 32 set-up. R7's medication administration record (MAR) dated February 1, 2025, through February 4, 2025, included: -simethicone 125 milligram (mg) chew (acid indigestion), give one chew by mouth twice daily. This is in a medication box not a card labeled with her name and medications. R7's prescriber order dated December 12, 2024, included the above order. On February 4, 2025, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-G review R7's MAR. ULP-G removed several medication cards (bubble packed medications) and a preset medication box from the locked medication cart. ULP-G prepared and administering R7's morning medication, to include one medication from the preset medication box. On February 5, 2025, at 11:38 a.m., clinical nurse supervisor (CNS)-C stated she had not revised R7's service plan to include medication set up, which was a service offered by the licensee. The licensee's Contents of Service Plans policy dated February 19, 2023, noted service plans were reviewed and revised as needed based upon on-going resident assessment. The facility will implement and provide all services required by the current service plan unless unable for reasons such as, but not including resident refusals. The service plan and revisions would be entered into the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01640		

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01640	Continued From page 33 (21) days	01640		
01750 SS=E	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, 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 records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for two of three residents (R7, R4). 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:	01750		

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01750	Continued From page 34 R7 R7's diagnosis included asthma, bipolar disorder (extreme mood swings, extreme excitement episodes or extreme depressive feelings), insomnia, impaired fasting blood sugar, peptic ulcer disease and gastroesophageal reflux disease (GERD/where stomach content persistently and regularly flows up into the esophagus). R7's service plan effective date November 28, 2024, authenticated January 8, 2025, by the resident, and January 21, 2025, by the facility representative, included medication administration. R7's medication administration record (MAR) dated February 1, 2025, through February 4, 2025, included: -polyethylene glycol 3350, mix one capful (17 grams) in liquid and take by mouth once daily (constipation). R7's prescriber order dated December 12, 2024, included the above order. On February 4, 2025, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-G review R7's medication administration record (MAR). ULP-G removed several medication cards (bubble packed medications) and a medication preset dosage box from the locked medication cart. ULP-G opened a bottom drawer in the medication cart and picked up a container of polyethylene glycol and reviewed the label. ULP-G returned the polyethylene glycol to the bottom drawer and stated that container of polyethylene did not belong to R7. ULP-G prepared and administered R7's morning	01750		

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01750	Continued From page 35 medication. On February 4, 2025, at 3:52 p.m., the surveyor reviewed R7's MAR with clinical nurse supervisor (CNS)-C. CNS-C stated she would have to reach out to the pharmacy or prescriber for polyethylene administration directions. CNS-C added R7 liked prune juice. CNS-C confirmed R7's record did not include specific instructions as required relating to how much liquid and types of liquid the medication could be mixed with. The manufacturer's directions for polyethylene glycol 3350, dated 2025, included add the right dose to four to eight ounces of water, juice, soda, coffee or tea. Do not mix this medication with foods or other liquids. R4 R4's diagnoses included diabetes, asthma, depression, and blindness. R4's service plan dated November 29, 2024, and authenticated December 30, 2024, indicated R4 received medication administration four times daily. R4's MAR dated February 1, 2025, through February 4, 2025, included: -Arnuity Ellipta 100 micrograms (mcg) inhale one puff by mouth once daily (asthma). R4's prescriber order dated December 13, 2024, included the above order. On February 4, 2025, at 8:20 a.m., the surveyor observed ULP-F hand an Arnuity Ellipta inhaler to R4. ULP-F told R4, "I have water for you to drink after the inhaler, the inhaler won't taste good." ULP-F handed R4 a glass of water, "to rinse your	01750		

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MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

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01750	Continued From page 36 (R4's) mouth out", after the administration of the inhaler. After the above observation the surveyor and ULP-F reviewed R4's MAR. R4's MAR did not include instructions to rinse mouth after inhaler use. On February 4, 2025, at 4:02 p.m., R4's record was reviewed with CNS-C. CNS-C stated R4's MAR did not include specific instructions, such as to rinse mouth after inhaler use. CNS-C asked if ULP had instructed R4 to rinse mouth after use. CNS-C stated she was new to assisted living and was "getting it" (that specific instructions are required in resident's records). The manufacturer's instructions for Arnuity Ellipta, dated March 5, 2023, included: -rinse your mouth with water after you have used the inhaler and spit the water out to reduce the risk of oropharyngeal candidiasis (yeast). -do not swallow the water. The licensee's Administration Medication, Treatment and Therapy by Unlicensed Personnel policy dated February 19, 2023, noted the RN had developed written, specific instruction for each resident and the RN had communicated with the ULP about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup	01770		

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01770	Continued From page 37 Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of two residents (R7) 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 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). The findings include: On February 3, 2025, at 10:18 a.m., during the entrance conference clinical nurse supervisor (CNS)-C stated one resident currently had a medication set up service provided at the facility (R4). R7's diagnosis included asthma, bipolar disorder (extreme mood swings, extreme excitement episodes or extreme depressive feelings), insomnia, impaired fasting blood sugar, peptic ulcer disease and gastroesophageal reflux disease (GERD- where stomach content persistently and regularly flows up into the	01770		

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01770	Continued From page 38 esophagus). R7's service plan effective date November 28, 2024, authenticated January 8, 2025, by the resident, and January 21, 2025, by the facility representative, included medication administration. R7's service plan did not include medication set-up. R7's medication administration (MAR) dated February 1, 2025, through February 4, 2025, included: -simethicone 125 milligrams (mg) chew, give one chew by mouth twice daily. This is in a medication box, not a card, labeled with her name and medication. R7's prescriber order dated December 12, 2024, included the above order. On February 4, 2025, at 7:50 a.m., the surveyor observed unlicensed personnel (ULP)-G review R7's MAR. ULP-G removed several medication cards (bubble packed medications) and a medication preset dosage box from the locked medication cart. ULP-G prepared and administered R7's morning medication to include the medication from the preset dosage box. R7's records lacked documentation for medication setup at the time of setup to include the dates of medication setup, the name of the medication, quantity of dose, times to be administered, route of administration, and name of person completing the medication setup. On February 5, 2025, at 9:25 a.m., CNS-C stated R7's record did not include medication setup	01770		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01770	Continued From page 39 documentation. CNS-C stated she filled the medication dosage box but did not complete any of the required documentation. The licensee's Medication Management Services policy dated February 19, 2023, noted documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01880 SS=F	144G.71 Subd. 19 Storage of medications 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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the medication was stored according to manufacturer's instructions by maintaining acceptable medication refrigerator temperatures for one of one medication refrigerator. In addition, the licensee failed to ensure medications were secure and permitted access to only authorized personnel in one of two medication carts (House B). Also, the licensee failed to ensure medication was securely stored and only authorized personnel had access to medication being stored	01880		

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	30666	A. BUILDING: _____ B. WING _____	02/05/2025

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01880	Continued From page 40 by the licensee for one of one medication refrigerator. 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 of the residents). The findings include: MEDICATION REQUIRING REFRIGERATION On February 3, 2025, at approximately 10:50 a.m. clinical nurse supervisor (CNS)-C stated the temperature of the medication refrigerator was 35 degrees Fahrenheit (F). CNS-C stated the temperature should be between 35 to 42 degrees F. CNS-C observed and confirmed the following: - one Wegovy (diabetes/weight loss) pen, 1.7 milligrams (mg)/0.75 milliliters (ml) for R8 - one latanoprost 0.005% (high eye pressure) eye solution for R6 - one Ozempic (diabetes/weight loss) pen, 2 mg for R2 - one Toujeo (long-acting) insulin pen, 300 units/ml for R4 - four Humalog (short-acting) insulin pen,100 units/ml for R4 - one Wegovy 0.25 mg/0.5 ml for R8 - four Wegovy 1 mg for R8 - three Wegovy 0.5 mg for R8 - one Shingrix vial kit (shingles vaccine) for R3 - one Adacel Tdap (booster against tetanus, diphtheria, and pertussis) for R10 - one Shingrix for R11 - one Fluad Trivalent (flu vaccine) for R10 - one Comirnaty 24/25 (COVID-19 vaccine) for	01880		

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01880	Continued From page 41 R3 - one Adacel Tdap for R3 - one Fluad Trivalent for R3 - one Abrysvo (RSV/respiratory syncytial virus vaccine) 0.5 ml for R10 - one Abrysvo 0.5 ml for R3. On February 3, 2025, at 2:15 p.m., the temperature log for the medication refrigerator dated January 1, 2025, through February 3, 2025, was reviewed with licensed assisted living director (LALD)-A. LALD-A confirmed the following: - 28 of 34 opportunities the temperature was recorded and within range. Directly after the above observation, LALD-A stated her expectation was that chores were completed as written. LALD-A stated the medication refrigerator temperature should have been monitored daily. The manufacturer's instructions for Wegovy dated January 2025, noted store the Wegovy pen in the refrigerator from 36 F to 46 F. Throw away pen if Wegovy has been frozen. The manufacturer's instructions for latanoprost dated February 1, 2024, noted store in the refrigerator. Do not freeze. The manufacturer's instructions for Ozempic dated October 2023, noted Ozempic should stay refrigerated until the first time you use it. You should keep it in the refrigerator (between 36 F to 46 F) when it's new and unused. The manufacturer's instructions for Toujeo dated February 2015, noted Toujeo pens should be stored in a refrigerator, 36 F to 46 F.	01880		

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01880	Continued From page 42 The manufacturer's instructions for Humalog Kwikpen dated April 2020, noted store unused pens in the refrigerator at 36 degrees F to 46 degrees F. Do not freeze your insulin. Do not use if it had been frozen. The manufacturer's instructions for Shingrix dated October 2024, noted refrigerate both vials between 36 F to 46 F. Discard if frozen. The manufacturer's instructions for Fluad Trivalent U.S. approval 2015, revised: MM/YYYY (not filled in on package insert) noted, store Fluad refrigerated at 36 F to 46 F. Do not freeze. Discard if the vaccine has been frozen. The manufacturer's instructions for Comirnaty dated September 2024, noted store pre-filled syringes refrigerated at 35-46 F. Do not freeze. The manufacturer's instructions for Adacel Tdap dated September 6, 2022, noted store refrigerated 36 F-46 F. Do not freeze vaccine or expose to freezing temperatures. The manufacturer's instructions for Abrysvo dated January 2025, noted store refrigerated at 36 F to 46 F. Do not freeze. Discard if the carton has been frozen. MEDICATION CART HOUSE B On February 3, 2025, at approximately 10:30 a.m., during a tour of the facility with CNS-C the surveyor observed a Trelegy Ellipta 100-62.5-25 microgram (mcg) inhaler (shortness of breath/wheezing) for R3 unopened on top of House B medication cart, located off the main entrance in an open common's area. CNS-C	01880		

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01880	Continued From page 43 stated she had just put the inhaler on top of the cart and had not secured it. The surveyor observed one resident in the common's area and no other staff. CNS-C stated the inhaler should have been secured and not left on top of the medication cart. On February 4, 2025, at 3:08 p.m., the surveyor observed an unlocked medication cart in House B, in the opened common's area off the main entrance. ULP-K and CNS-C's backs positioned to the medication cart. CNS-C stated the medication cart should be locked not in use and left unattended. MEDICATION REFRIGERATOR HOUSE A On February 3, 2025, at 3:35 p.m., the surveyor observed the door to the medication room (in a hallway, last door prior to the open common's/dining area) where the unsecured medication refrigerator was stored. ULP-E was in the kitchen area standing at the sink with her back to the five residents who were seated at the table. Directly after the above observation ULP-E stated she had "just got to the site" and did not realize the door was open. ULP-E stated the door to the medication room should be closed and locked. See refrigerator content listed above. On February 3, 2025, at 3:49 p.m., CNS-C stated the door to the medication room should be locked. The licensee's Medication Management Services policy dated February 19, 2023, an assisted living facility must ensure all prescription medications in securely locked and substantially constructed	01880		

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01880	Continued From page 44 compartment according to the manufacturer's directions and permit only authorized personnel to have access. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information, including the expiration date, for time sensitive medications for two of two medication carts (House A, House B). In addition, the licensee failed to monitor for expired medication for one of ten residents (R5). 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).	01890		

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01890	Continued From page 45 The findings include: On February 3, 2025, at approximately 10:40 a.m., the surveyor and clinical nurse supervisor (CNS)-C reviewed the contents of the locked medication carts. CNS-C observed and confirmed the following: HOUSE B - one opened latanoprost (eye pressure) 0.005% for R6 not dated - one opened fluticasone proprionate and salometer inhaler (prevent asthma attacks) 100/50 micrograms (mcg) dated January 12, 2025, for R7. HOUSE A - one opened liraglutide (diabetes) 18 milligrams (mg)/three milliliters (ml) for R4 not dated - one opened Arnuity Ellipta inhaler (prevent/control asthma) 100 micrograms (mcg) for R4 dated January "20/ 25". EXPIRED MEDICATION -one opened lidocaine pain relief cream for R5 expiration dated December 2024. On February 3, 2025, at 4:08 p.m., CNS-C stated "everyone" (all ULPs) had multiple training on writing an open and expiration dates on time sensitive medications. CNS-C stated it was her (CNS-C's) expectation that time sensitive medication included a complete and legible open and an expiration date. In addition, CNS-C stated expired medication should be removed from the medication cart. CNS-C stated ULPs not dating time sensitive medication was a widespread issue.	01890		

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01890	Continued From page 46 The manufacturer's instruction for latanoprost dated February 1, 2024, noted you may keep the opened bottle in the refrigerator or at room temperature for up to six weeks. The manufacturer's instruction for fluticasone proprionate and salometer dated January 2020, noted write the date you opened the pouch on the first line of the label and the "use by" date on the second line of the label. The "use by" date is one month after the date you opened the pouch. The manufacturer's instructions for liraglutide dated June 12, 2024, noted once the pen was used, it was good for 30 days. The manufacture's instruction for Arnuity Ellipta dated March 5, 2023, noted store Annuity Ellipta in the unopened tray and only open when ready for use. Safely throw away Annuity Ellipta in the trash six weeks after your open the tray or when the counter reads "0", whichever comes first. Write the date you open the tray on the label on the inhaler. The licensee's Medication Management Services policy dated February 19, 2023, noted prescription drugs, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond use date of a time dated rug. In addition, the facility must verify that the medications are up to date and stored as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01950	Continued From page 47	01950		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy 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: (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 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for three of four residents (R4, R3, R8) receiving treatments. 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	01950		

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01950	Continued From page 48 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on February 3, 2025, at 10:20 a.m., clinical nurse supervisor (CNS)-C stated the facility currently had one BG system in place which was a Libre system (measures glucose levels through a small sensor, the size of two stacked quarters, applied to the back of an upper arm). R4 R4's diagnoses included diabetes. R4's service plan dated November 29, 2024, and authenticated December 30, 2024, indicated R4 received BG monitoring four times daily. R4's Rtask (computer system used) service, record, BG 8:00 a.m., active August 21, 2018, noted: - wearing gloves and following agency procedure, check BG and record. Notify nurse if blood sugar falls below 70 and is above 400 R4's January 1, 2025, through January 31, 2025, medication administration record (MAR) included: - Free Style Libre Sensor (every 14 days) removed old sensor, cleanse and place new sensor in new location. R4's prescriber's order dated December 13, 2024, included: - blood glucose four times per day, wearing gloves and following agency procedure, check blood glucose and record. Notify nurse if blood sugar falls below 70 and above 400.	01950		

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01950	Continued From page 49 R4's assessment completed January 21, 2025, included: - needs blood sugar (BG) checks and assistance with insulin - uses insulin, trained staff will administer insulin as ordered and report any blood sugars over 350 to nursing, or any blood sugars under 100 to nursing. On February 4, 2025, at 7:54 a.m., the surveyor observed unlicensed personnel (ULP)-F get keys to the locked medication cart. ULP-F stated R4 wanted a "finger poke" BG test done. ULP-F gathered a BG (meter device that will test blood sample to determine blood glucose level), alcohol pad, testing strip, and lancet (small needle used to poke the skin [usually on a finger] to get a small drop of blood). ULP-F took R4 and the BG testing supplies R4's room. With correct technique ULP-F obtained a BG reading of 453. ULP-F commented the BG was "a little high" and ULP-F stated she would inform the RN of R4's BG level. On February 4, 2025, at 8:03 a.m., ULP-F stated R4 had a BG scanner in-place (Libre system), however R4's BG scanner had read "hi", so ULP-F did a finger poke BG test. On February 4, 2025, at approximately 8:35 a.m., R4's record was reviewed with ULP-G. ULP-G stated R4's record did not include specific instructions for R4's BG monitoring to include which type of system was used, or to notify RN of other issues other than the BG reading. On February 5, 2025, at 8:57 a.m., R4's record was reviewed with CNS-C. CNS-C stated R4's record did not include clear instructions regarding	01950		

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01950	Continued From page 50 R4's BG monitoring, to include which type of system to use and when. CNS-C stated she currently changes out R4's BG sensor, adding she will train ULPs to complete the task in the future. CNS-C confirmed ULPs may not read the entry in R4's MAR to change out the Libre system since CNS-C currently changes out the system. CNS-C also stated R4's assessment for BG monitoring did not match what was in the record and it should. CNS-C stated ULPs were able to review R4's assessment for BG monitoring. CNS-C confirmed R4's record did include specific instruction for BG monitoring. R3 R3's diagnoses included supplemental oxygen dependent, chronic obstructive pulmonary disease (COPD/chronic inflammatory lung disease that causes obstructed airflow from the lungs), and anxiety. R3's service plan dated December 31, 2024, included oxygen delivery, three times per day. RTask, service, oxygen delivery, active dated June 3, 2024, noted: - oxygen delivery as ordered: three liters per minute (LPM). Notify nurse, if any concerns with concentrator. R3's MAR dated January 1, 2025, through January 31, 2025, included: - oxygen, three LPM please check and ensure residents oxygen is on and continuously running at three LPM. On February 4, 2025, at 8:42 a.m., the surveyor observed ULP-G prepare R3's morning medication to include a Trilogy Ellipta inhaler (COPD), six oral medications, and a Boost	01950		

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01950	Continued From page 51 (nutritional supplement.) ULP-G took the prepared medication to R3's room. R3 wore a nasal cannula (NC/ a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) that was connected to an oxygen concentrator. ULP-G administer R3's medication. On February 3, 2025, at 2:10 p.m., the surveyor and CNS-C observed oxygen tanks in R3's room. R8 R8's diagnoses included chronic respiratory failure with hypoxia (low oxygen in blood), asthma, sleep apnea, and morbid obesity. R8's service plan dated June 3, 2024, indicated R8 received oxygen delivery three times daily. R8's Rtask service record oxygen delivery, active April 9, 2024: noted - oxygen delivery as ordered, three LPM - notify nurse: if tank is low or empty. R8's prescriber order dated October 31, 2024, included Oxygen 1-3 liters, continually, client (resident) states that she has been on three liters to keep oxygen SATS (saturation) above 90%. On February 3, 2025, at approximately 11:15 a.m., during a tour of the facility with CNS-C the surveyor observed signage of oxygen use outside of R8's room. R8 was in her room, wearing a NC that was connected to an oxygen concentrator. The surveyor and CNS-C observed oxygen tanks in R8's room. On February 4, 2025, at 10:11 a.m., the surveyor observed ULP-G state that ULP-F had just assisted with R8's morning shower. ULP-G went	01950		

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01950	Continued From page 52 to check on R8 to make sure R8 was safe. R8 was seating on the toilet wearing a NC. On February 4, 2025, at 4:23 p.m., CNS-C stated there were not very specific instructions in R3's and R8's record for oxygen administration to include when ULPs should notify RN of concerns. CNS-C stated she was not able to state what she would like ULPs to report to her regarding oxygen use. CNS-C added she would have to look up signs and symptoms to report. The surveyor asked CNS-C if she would like ULPs to report respiratory issues such as shortness of breath (SOB), increased confusion, skin discoloration, skin breakdown around nose or ears? CNS-C replied she would like ULP to report all of that. The licensee's Administration Medication, Treatment and Therapy by Unlicensed Personnel policy dated February 19, 2023, noted the RN (registered nurse) had developed written, specific instruction for each resident and the RN had communicated with the ULP about the individual needs of the resident. The licensee's Administration of Oxygen by Nasal Cannula dated May 7, 2023, noted position tips of cannula properly in nares and adjust elastic headband or plastic slide on cannula so that a snug comfortable fit is achieved. If the tubing is positioned with a slide to fit behind the ears and under the chin, check skin condition behind the ears. Notify nurse of skin redness or breakdown. The undated licensee's Oxygen Therapy policy noted inspect the skin over the ears and in the nostrils for any redness or breakdown from too tight an application of the cannula. Contact the nurse supervisor if any of the following occurs: -increased respiration rate	01950		

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	30666	A. BUILDING: _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 53 -change in level of consciousness -increased confusion -pain. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of cleaning products. Further, the door to the commercial kitchen was left unattended and unsecured. In addition, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of oxygen for two of two residents (R8, R3) with oxygen tanks. 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	02310		

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	30666	A. BUILDING: _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 54 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The assisted living held a dementia care license with a current census of 14 residents. On February 3, 2025, at 10:07 a.m., during the entrance conference licensed assisted living director (LALD)-A stated the facility was licensed for dementia care. During a tour of the facility on February 3, 2025, from 10:38 a.m. until 11:32 a.m., with LALD-A and clinical nurse supervisor (CNS)-C, LALD-A stated the facility consisted of two houses, House A (ten residents), House B (four residents). The two houses were joined by a commons area. LALD-A and CNS-C observed and confirmed the following: CLEANING SUPPLIES HOUSE B - a spray bottle of Q.T. Plus, ready to use (disinfectant/cleaner), with approximately a third of the bottle remaining in an unlocked bathroom - an opened container of disinfecting wipes, fresh scent, in an unlocked common's area bathroom. HOUSE A - an opened container of disinfecting wipes, orange scent, in an unlocked common's area bathroom - a container of Ajax ultra dish soap with approximately a third of the bottle remaining positioned by a sink in an activity area/kitchen area - an opened container of dishwasher packs under the unlocked sink area in the activity/ kitchen area	02310		

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	30666	A. BUILDING: _____ B. WING _____	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 55 - an opened spray bottle of sanitizer, located in an unlocked laundry room - an opened spray bottle of Q.T. Plus, located in an unlocked laundry room - an opened spray bottle of "bleach for sanitizing", located in an unlocked laundry room - an opened bag of Purex "4 in 1" laundry pods, located in an unlocked laundry room - four unopened bags of Purex "4 in 1" laundry pods. Directly after the above observation owner (O)-B stated the licensee was not using their dementia care license. O-B stated the part of facility which was secure housed no residents and was not in use. O-B stated he thought that only in secured units chemicals needed to be secured. KITCHEN DOOR On February 4, 2024, at 6:29 a.m., the surveyor observed the entrance to the commercial kitchen unsecured. The entrance to the kitchen consisted of two swinging doors. On each door was a sign, "Employees Only". There was a hasp type of closure attached to each of the doors with a coded Master four-digit combination padlock, the shackle was not engaged, hanging off of one of the doors to the kitchen unsecured. On February 3, 2025, at 2:46 p.m., the surveyor observed the kitchen unsecured and kitchen/unlicensed personnel (K/ULP)-J in the office, talking with LALD-A. LALD-A stated the kitchen door should be secured when not attended. K/ULP-J confirmed there was an opened bottle of Ajax dish soap by the kitchen sink. K/ULP-J stated knives were in plastic drawers, not secured-K/ULP-J stated the kitchen doors have a locking system that was to be used, and the kitchen was to be secured, or occupied.	02310		

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02310	Continued From page 56 The Safety Data Sheet for Q.T. Plus dated July 22, 2020, noted: - may cause irritation to the respiratory system. May cause allergy or asthma symptoms or breathing difficulties if inhaled. Prolonged inhalation may be harmful. - causes severe skin burn. May cause an allergic skin reaction - causes severe eye burns. Causes serious eye damage - causes digestive tract burns - burring pain and severe corrosive skin damage. Causes serious eye damage. Symptoms may include stinging, tearing, redness, swelling, and blurred vision. Permanent eye damage including blindness could result and difficulty in breathing. - do not get in eyes, on skin, or on clothing - store locked up. Keep away for heat, sparks and open flame. Store in tightly closed container. Do not contaminate water, food or feed by storage or disposal. Open dumping is prohibited. Store in original container in areas inaccessible to children. The Safety Data Sheet for Clorox Disinfecting Bio Stain and Odor Remover dated July 7, 2017, noted: - inhalation: remove to fresh air. If symptoms persist, call a physician - eye contact: rinse eyes. Get medical attention if irritation develops and persists - skin contact: wash skin with soap and water. Get medical attention if irritation develops and persists - ingestion: clean mouth with water and rinse afterwards with plenty of water. Never give anything by mouth to an unconscious person. Do NOT induce vomiting. Call a physician.	02310		

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02310	Continued From page 57 The Safety Data Sheet for Ajax Ultra Dishwashing Hand Liquid Orange dated July 30, 2018, noted: - warning, causes serious eye irritation - rinse cautiously with water for several minutes. Remove contact lenses, if present and easy to do. Continue rinsing. - if eye irritation persists get medical advice/attention. The Safety Data Sheet for Disinfectant/Cleaner dated January 8, 2020, noted: - Danger, causes severe skin burns and eye damage. Causes serious eye damage. May cause damage to organs through prolonged or repeated exposure - do not breathe mist/vapors. Wash thoroughly after handling. Wear protective gloves/protective clothing/eye protection/face protection - first aid if in eye: hold eye open and rinse slowly and gently with water for 15-20 minutes Remove contact lenses, if present, after the first five minutes, then continue rinsing eye. IF ON SKIN OR CLOTHING, take off contaminated clothing. Rinse skin immediately with plenty of water for 15-20 minutes. IF SWALLOWED: Call a poison control center or doctor immediately for treatment advice. Have person sip a glass of water, if able to swallow. Do not induce vomiting unless told to do so by the poison control center or doctor. Have the product container or label with you when calling a Poison Control Center or doctor or going for treatment. The Safety Data Sheet for Great Value Dishwasher Powder Pacs dated July 16, 2023, noted: - may be harmful if swallowed - may cause skin, eye, and respiratory tract irritation - product dust may be irritating to eyes (severely	02310		

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02310	Continued From page 58 irritating to eyes), skin and respiratory system - handle in accordance with good industrial hygiene and safety practice. Avoid contact with skin, eyes and clothing. ear personal protective equipment - store in original container. Keep out of the reach of children. The Safety Data Sheet for Clorox Commercial Solutions Clorox Disinfecting Wipes-Fresh Scent, dated January 5, 2025, noted: - exposure to vapor or mist may irritate respiratory tract - liquid may cause irritation - liquid may cause slight irritation - ingestion of liquid may cause slight irritation to mucous membranes and gastrointestinal tract - liquid may cause redness and tearing of eyes; avoid contact with eyes - handle in accordance with good industrial hygiene and safety practice. Avoid contact with eyes, skin, and clothing Do not eat, drink, or smoke when using this product: - keep containers tightly closed in a dry, cool, and well-ventilated place. The Safety Data Sheet for sanitizer dated May 11, 2015, noted: - Danger - causes severe skin burns and eye damage. Causes serious eye damage. Very toxic to aquatic life - do not breathe mist or vapor. Wash thoroughly after handling. Wear protective gloves/protective clothing/eye protection/face protection - if swallowed: rinse mouth. Do NOT induce vomiting. If on skin (or hair): take off immediately all contaminated clothing. Rinse skin with water/shower. If inhaled: removed person to fresh air and keep comfortable for breathing. If in eyes,	02310		

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02310	Continued From page 59 rinse cautiously with water for several minutes. Immediately call a poison center/doctor. Wash contaminated clothing before reuse. Collect spillage - store locked up. The Safety Data Sheet for bleach dated March 9, 2021, noted: - Danger - causes skin irritation. causes serious eye damage - if on skin: wash with plenty of water. If skin irritation occurs, get medical attention. Take off contaminated clothing and wash it before reuse - if in eyes: rinse cautiously with water for several minutes. Remove contact lenses., if present and easy to do. Continue rinsing. Immediately call a POISON CENTER or doctor. The Safety Data Sheet for Purex 4 in 1 dated April 20, 2025, noted: - wash thoroughly after handing - wear eye and face protection - wear protective gloves - do not get in your eyes or on skin. Do not ingest. Use with adequate ventilation. Keep the containers closed when not in use. The Minnesota Bill of Rights dated November 8, 2022, noted residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. OXYGEN STORAGE R8 On February 3, 2025, at approximately 11:15	02310		

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02310	Continued From page 60 a.m., during a tour of the facility with CNS-C the surveyor observed signage of oxygen use outside of R8's room. R8 was in her room, wearing a nasal cannula (a lightweight tube which on one end splits into two prongs which are placed in the nostrils to deliver supplemental oxygen) that was connected to an oxygen concentrator. The surveyor and CNS-C observed one oxygen tank secured in R8's room and one smaller oxygen tank unsecured in R8's room. CNS-C stated she was going to have to get creative to develop a way to secure R8's smaller oxygen tank. CNS-C said all oxygen tanks were to be secured. CNS-C stated she could "show" the surveyor another room, where oxygen tanks were securely stored. R3 On February 3, 2025, at 2:10 p.m., the surveyor and CNS-C observed 11 secured oxygen tanks in R3's room and two unsecured oxygen tanks. CNS-C stated she, just checked R3's oxygen tanks yesterday and R3's oxygen tanks were all secured. CNS-C said oxygen tanks should be secured. The Minnesota Home Care Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to date service plan subject to accepted health care standards. The licensee's Administration of Oxygen by Nasal Cannula policy dated May 7, 2023, noted assure oxygen deliver device is stored per the registered nurse (RN) instruction sheet. (Cylinder and oxygen tanks are stored upright. Concentrations are to be stored in a well-ventilated area.)	02310		

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02310	Continued From page 61 The undated licensee's Oxygen Therapy policy noted oxygen cylinders must be placed in a cart or base to avoid dropping or bumping the tank. Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements, dated April 16, 2020, indicated oxygen cylinders must be secured (chains or racks) to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Follow-Up
Date: *02/04/25*
Time: 14:54:49
Report: 7939251020

Food and Beverage Establishment Inspection Report

Location:
Maple Woods Assisted Living
40170 County Road 257
Cohasset, MN55721
Itasca County, 31

Establishment Info:
ID #: 0038603
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2189999072
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.

No NEW orders were issued during this inspection.

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

ALL ORDERS CORRECTED, HAND WASH SINK OPERATING WITH BOTH HOT AND COLD WATER.

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

I acknowledge receipt of the MINNESOTA DEPARTMENT OF HEALTH inspection report number 7939251020 of 02/04/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
TAMMY MILLER
MANAGER/CFPM

Signed:_____
RYAN TRENBERTH
SAN III
BEMIDJI DISTRICT OFFICE
218-308-2133
ryan.trenberth@state.mn.us

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *02/03/25*
Time: 12:56:35
Report: 7939251017

Food and Beverage Establishment Inspection Report

Location:
Maple Woods Assisted Living
40170 County Road 257
Cohasset, MN55721
Itasca County, 31

Establishment Info:
ID #: 0038603
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2189999072
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

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

HAND SINK HAS NOT COLD WATER ONLY HOT WATER IS OPERATIONAL

Comply By: 02/03/25

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Hot Water: = at >160F Degrees Fahrenheit
Location: WARE WASH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: YOGURT
Temperature: 39 Degrees Fahrenheit - Location: UPRIGHT FRIDGE
Violation Issued: No

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

DISCUSSION
ENSURE SEPTIC SYSTEM IS REGULARLY INSPECTED WHEN WEATHER PERMITS.

FOLLOW-UP INSPECTION WILL OCCUR TO ENSURE HAND SINK IS FUNCTIONAL

Type: Full
Date: *02/03/25*
Time: 12:56:35
Report: 7939251017
Maple Woods Assisted Living

Food and Beverage Establishment Inspection Report

ALL ITEMS COOKED FOR SERVICE AND LEFTOVERS ARE NOT RESERVED

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

I acknowledge receipt of the MINNESOTA DEPARTMENT OF HEALTH inspection report number 7939251017 of 02/03/25.

Certified Food Protection Manager:_____

Certification Number: FM47019 Expires: 03/15/27

Inspection report reviewed with person in charge and emailed.

Signed: NA

TAMMY MILLER
MANAGER/CFPM

Signed: Ryan Trenberth

RYAN TRENBERTH
SAN III
BEMIDJI DISTRICT OFFICE
218-308-2133
ryan.trenberth@state.mn.us