Electronically Delivered

June 10, 2024

Licensee
Maple Care Homes
8421 Upland Lane North
Maple Grove, MN 55311

RE: Project Number(s) SL33109015

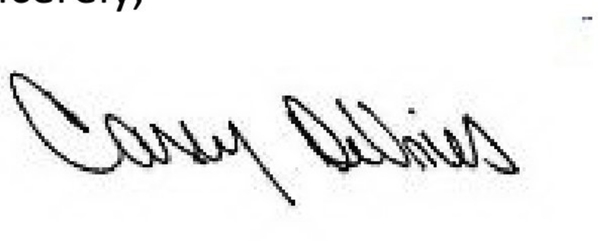
Dear Licensee:

On May 28, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the March 1, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

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Electronically Delivered

March 21, 2024

Licensee
Maple Care Homes
8421 Upland Lane North
Maple Grove, MN 55311

RE: Project Number(s) SL33109015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 1, 2024, 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.

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 . . ."

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also

may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0495 - 144g.41 Subd. 1 (14) - Minimum Requirements = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

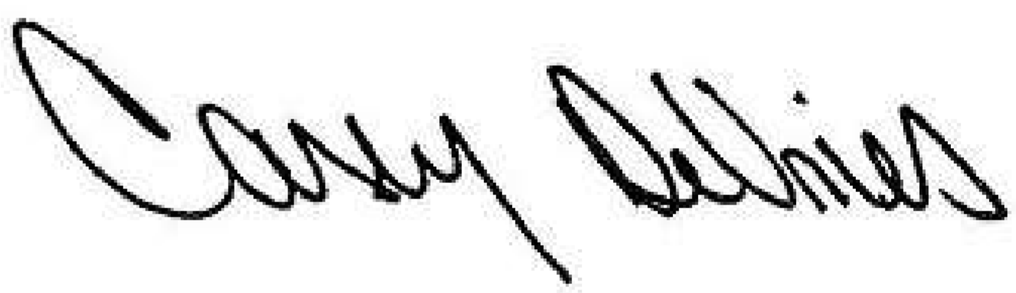
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33109	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CARE HOMES	8421 UPLAND LANE NORTH MAPLE GROVE, MN 55311

(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 ******ATTENTION****** 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: SL33109015-0 On February 26, 2024, through March 1, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents: all of whom received services under the Assisted Living license. An immediate correction order was identified on February 27, 2024, issued for SL33109015-0, tag identification 0495. The immediacy of 0495 was not removed at the time of exit on March 1, 2024.	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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. 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 subd. 1, 2, and 3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a written staffing plan that included an evaluation completed by the clinical nurse supervisor (CNS) (as indicated in Minnesota Administrative Rule 4659.0180) at least twice a year. 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	0 470		

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0 470	Continued From page 2 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 February 26, 2024, at 10:18 a.m., during the entrance conference house manager (HM)-B stated licensee had a staffing plan but could not recall when it was last updated. The surveyor requested to review the staffing plan after the entrance conference. On February 26, 2024, at 11:12 a.m., the surveyor requested to review licensee's staffing plan. HM-B stated it was licensee's understanding that the daily staffing schedule served the same purpose as a staffing plan, and it was reviewed daily. The licensee's Staffing policy dated August 1, 2021, indicated the clinical nurse supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet residents' needs at all times, including reasonably foreseeable needs. Also indicated the staffing plan to determine the required staffing level is prepared by the clinical nurse supervisor. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 495 SS=I	144G.41 Subd. 1 (14) Minimum Requirements	0 495		

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0 495	Continued From page 3 (14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff and residents had access to a registered nurse ((clinical nurse supervisor) (CNS)-A) on-call for current and foreseeable needs 24 hours a day, seven days per week due to CNS-A holding full time employment at another health care provider. This had the potential to affect all residents and staff of the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). This resulted in an immediate order for correction on February 27, 2024, at approximately 10:40 a.m. The findings include: On February 26, 2024, at 10:18 a.m., during the entrance conference, house manager (HM)-B stated clinical nurse supervisor (CNS)-A was not available on site and provided a cell phone number to contact him. On February 26, 2024, at 10:20 a.m., the surveyor called CNS-A over the phone and CNS-A stated he was not available for the survey	0 495		

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0 495	Continued From page 4 as he was working at his full-time job. When the surveyor asked him the place of his full-time job, CNS-A stated Allina hospital. On February 26, 2024, at 11:32 a.m., the surveyor inquired to unlicensed personnel (ULP)-C who she could call in case of a medical emergency, ULP-C stated she would call CNS-A. The surveyor further asked her if CNS-A did not answer who she would call. ULP-C stated she would call registered nurse (RN)-D. Then the surveyor requested ULP-C to provide the contact phone number for RN-D. ULP-C stated that information was available on the posted phone list, however when ULP-C and the surveyor went through the posted list RN-D's name and phone number were missing. ULP-C stated she could find the number in Rtask (documentation software). When ULP-C went through the list in the Rtask she could not find RN-D's name nor phone number. ULP-C stated if she logged into the Brooklyn Park location (another assisted living facility location owned by licensee's parent company) she would be able to find the requested information. ULP-C logged into Rtask Brooklyn Park location, and she was able to find RN-D's name and phone number. On February 26, 2024, at 11:45 a.m., via phone, the surveyor spoke with RN-D. RN-D stated she never works for the licensee's Maple Grove location, has never received any calls from the staff in Maple Grove, and denied being an on-call RN for the Maple Grove location. RN-D stated she only works at the Apple Valley location (another location owned by the parent company) and only on the weekends to set up medications for residents. RN-D also stated she has only occasionally worked at the Brooklyn Park location and only covered for CNS-A in Maple Grove once	0 495		

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0 495	Continued From page 5 about two years ago when CNS-A was on a vacation. RN-D also stated she only worked for licensee's parent company part time but did not divulge whether she had another job. On February 26, 2024, at 12:49 p.m., via phone, CNS-A stated there was another nurse who stepped in when he was out on vacation. When the surveyor asked CNS-A what happens when staff call him when he is unable to answer, CNS-A stated they leave message for him to call back. CNS-A did not mention RN-D taking his calls when he was not able to answer. On February 27, 2024, at 8:02 a.m., during medication administration observation, the surveyor requested to know from ULP-E who she would call in case of a medical emergency. ULP-E stated she would call CNS-A. The surveyor further requested to know if CNS-A was not able to answer the call immediately, if there was any other nurse she would call. ULP-E stated she only knew of CNS-A. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 495		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes;	0 780		

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0 780	Continued From page 6 (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; (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 smoke alarms that complied with fire protection requirements. 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). The findings include: On February 27, 2024, at 12:10 p.m., survey staff toured the home with house manager (HM)-B. During the tour, survey staff observed the	0 780		

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0 780	Continued From page 7 following: 1. A smoke alarm was not installed outside and in the immediate vicinity of occupied resident bedroom 1 on the main floor. During the facility tour interview on February 27, 2024, HM-B verified a smoke alarm was not installed outside bedroom 1. 2. When the smoke alarms were tested in basement bedrooms 5 and 6, none of the other smoke alarms in the dwelling unit were activated. The smoke alarms installed in these bedrooms were not interconnected so that actuation of one alarm caused all alarms in the dwelling unit to operate. During the facility tour interview on February 27, 2024, HM-B verified the smoke alarms installed in bedrooms 5 and 6 were not interconnected. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of	0 800		

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0 800	Continued From page 8 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) 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: On February 27, 2024, at 12:10 p.m., survey staff toured the home with house manager (HM)-B. During the tour, survey staff observed the following: 1. The hardwired smoke alarm in occupied resident bedroom 1 did not work when tested. Properly maintained smoke alarms play a crucial role in providing early warning of a fire to the building occupants. During the facility tour interview on February 27, 2024, HM-B verified this smoke alarm was not working properly. 2. Egress doors: a. In occupied resident bedroom 2, a curtain and plastic film were installed over a door leading from the bedroom out to the back deck. When the curtain and plastic film were removed, part of the upper door trim was pulled out of the wall. Once the curtain and plastic were removed, a keypad lock and a separate thumb-turn deadbolt lock were observed to be installed on the inside of this door. During the facility tour interview on February 27, 2024, HM-B stated this door would be used as the emergency exit and not the windows. Egress doors must release from the	0 800		

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0 800	Continued From page 9 latched position in one operation. The licensee failed to maintain an egress door in occupied resident bedroom 2 in a continuous state of good repair and operation. The curtain and plastic film used to cover the door could limit the ability of occupants to safely exit the building in the event of an emergency. b. The front door of the home was designated as an exit on the posted floor plan and evacuation route. A keypad lock was installed on the inside of this door. Above the keypad lock, a flip-style lock was installed on the upper hinge of the door. Door latching hardware is required to be located not higher than 48" from the floor. Egress doors must release from the latched position in one operation. HM-B demonstrated a code was not required to open the door. During the facility tour interview on February 27, 2024, HM-B stated the keypad lock did not work and the facility used the flip lock installed on the hinge to lock this door. Survey staff noted the facility was not equipped with an automatic fire sprinkler system. Keypad locks installed on the inside of egress doors must interconnect with the fire safety systems and must default to an unlocked position under activation of the fire alarm, fire sprinkler system, or a loss of power. 3. Floor plan and escape routes: a. The posted upstairs floor plan and escape route did not label the doors leading from resident bedrooms 2 and 3 out to the back deck as exits. During the facility tour interview on February 27, 2024, HM-B explained these doors would be used as emergency exits and not the windows. HM-B verified the floor plan was inaccurate and did not label these doors as exits. b. The posted lower level floor plan and escape route directs occupants to exit the home using	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33109	A. BUILDING: _____ B. WING _____	03/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE CARE HOMES	8421 UPLAND LANE NORTH MAPLE GROVE, MN 55311

(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
0 800	Continued From page 10 two doors that leads out to the patio in the backyard. The backyard was enclosed by a fence with two gates, that were unlocked during the facility tour. Key-only locks were installed on both gates. All paths of egress must provide unobstructed exiting. During the facility tour interview on February 27, 2024, HM-B verified key-only locks were installed on both fence gates. 4. Burnt cigarettes were disposed of in an uncovered metal can on the back deck. The listed container for smoking material disposal was disconnected and sitting on the deck in two pieces, the container was not maintained in operable condition. Burnt cigarettes were observed being disposed of in an uncovered plastic garbage container on the back patio. Improper disposal of smoking materials increases the risk of structural fires. During the facility tour interview on February 27, 2024, HM-B verified burnt cigarettes were not disposed of properly and the listed container required repair. 5. A freezer was plugged into an extension cord in the basement storage room. Extension cords are intended for temporary use and should never be used to connect a major appliance. Extension cords used to power an appliance can lead to overheating and an increased risk of fire. During the facility tour interview on February 27, 2024, HM-B verified the extension cord was used improperly and the freezer needed to be plugged directly into a wall outlet. 6. In occupied resident bedroom 4 in the basement, a listed space heater was plugged into a power strip. Space heaters must not be plugged into power strips, which could overheat and result in a fire. During the facility tour interview on February 27, 2024, HM-B verified the power strip	0 800		

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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
0 800	Continued From page 11 was used improperly and this space heater needed to be plugged directly into a wall outlet. 7. In the basement recreation room, an electrical box with exposed capped wires was installed near the ceiling and not provided with a cover plate. Electrical boxes must be properly covered to protect against accidental contact with live electrical components. During the facility tour interview on February 27, 2024, HM-B verified a cover was not installed on this electrical box. 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) employee 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) Employees of assisted living facilities shall receive 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	0 810		

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0 810	Continued From page 12 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 employees 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, record review, and interview, the licensee failed to develop a fire safety and evacuation plan with the required content. 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 27, 2024, at 12:10 p.m., survey staff toured the home with house manager (HM)-B. During the tour, survey staff observed resident sleeping rooms were not accurately identified on the posted floor plan and escape route. 1. The upstairs floor plan shows two bedrooms. During the facility tour, survey staff observed three resident bedrooms. One of the resident	0 810		

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0 810	Continued From page 13 bedrooms was labeled as an office. 2. The downstairs floor plan shows two bedrooms. During the facility tour, survey staff observed three resident bedrooms. The facility floor plan was not maintained to accurately identify the location and number of resident sleeping rooms. During the facility tour interview on February 27, 2024, HM-B verified the floor plan was inaccurate and resident bedrooms were not properly identified. HM-B stated the basement was remodeled and one bedroom (labeled as bedroom 4 on the floor plan) had been divided to create two separate bedrooms. HM-B verified the floor plan labels bedrooms 5 and 6 as bedroom 4. On February 27, 2024, HM-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP fire safety policy dated August 1, 2021, was a template and had not been developed for use at this facility. The fire safety policy included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions for fire were limited to the acronym RACE (Remove, Alarm, Confine, and Extinguish or Evacuate). The fire safety policy did not identify specific fire protection procedures necessary for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke.	0 810		

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0 810	Continued From page 14 During an interview on February 27, 2024, at 2:35 p.m., HM-B verified the FSEP required revision. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident for all licensee's residents. This had the potential to affect all 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 February 26, 2024, at 11:05 a.m., house	0 970		

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0 970	Continued From page 15 manager provided the surveyor with a blank contract and stated the same was used for all licensee's residents. The licensee's Assisted Living Contract contained a waiver language in the following sections: - Section indemnification read - [licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless from any claims or damages unless caused solely by negligence of [licensee]. - Section insurance liability and release read - [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents. The resident hereby releases [licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [licensee] or its employees or agents. On February 26, 2024, at 2:30 p.m., house manager (HM)-B stated licensee was aware of the liability language used in the contract and was in the process of updating the contract. Also stated the same contract was used for all licensee's residents. No further information was provided.	0 970		

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0 970	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. 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) completed supervision of a ULP within 30 calendar days of beginning to provide delegated tasks and thereafter as needed based on performance for one of two employees (unlicensed personnel (ULP)-E).	01440		

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01440	Continued From page 17 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: ULP-E started employment with licensee on November 22, 2021, to provide assisted living services. On February 27, 2024, between 8:00 a.m., and 11:20 a.m., the surveyor observed ULP-E administer medications to licensee's residents. ULP-E's record lacked evidence a RN conducted direct supervision of ULP-E within 30 calendar days of performing delegated tasks or thereafter as needed based on performance. On February 28, 2024, at 11:30 a.m., house manager (HM)-B stated licensee's RN completes supervision of ULPs frequently but only documents if there are issues to follow up on. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup,	01770		

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01770	Continued From page 18 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 one resident (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 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: During the entrance conference on February 26, 2024, at 10:25 a.m., house manager (HM)-B stated the licensee provided medication management services which included medication setup by the registered nurse (RN) for one resident. R4 was admitted to the licensee for assisted living services on October 27, 2023. R4's unsigned Service Plan (Wavier) - Addendum to Contract, indicated R4 received assistance with medication administration, monitoring and assessments, and PRN (as needed) anxiety medication.	01770		

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01770	Continued From page 19 On February 27, 2024, at 8:59 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R4 to take medications from a medication organizer pill box. ULP-D stated the medication is set up by the registered nurse (RN) every week on Tuesdays. On February 28, 2024, at 12:20 p.m., HM-B provided the surveyor with a nursing note dated February 27, 2024, which indicated weekly medication set up was done. The note lacked the required content to include name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup. The licensee's Medication Administration policy dated August 1, 2021, indicated each medication administered by [licensee] staff will be documented in the resident's clinical record. The policy lacked verbiage to include medication set up documentation. 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	01880		

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01880	Continued From page 20 review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access. This had the potential to affect all five residents. 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: On February 27, 2024, at 7:35 a.m., the surveyor observed unlicensed personnel (ULP)-C retrieve medications from the closed office and bring them to administer to R4 to his room in the basement. When ULP-C did not find R4 in the room, she left the medications on the television stand unattended and returned upstairs to continue other chores. ULP-C returned to check R4 after about 10 minutes and asked him if he had taken his medications. When R4 indicated they had not, ULP-C grabbed the medications from the television stand and handed them to R4 with a glass of water to take the medication. On February 27, 2024, at 10:40 a.m., during the medication storage area review the surveyor observed the medication cabinet lock was not locking. When the surveyor asked about the unlocked medication cabinet, house manager (HM)-C stated she had noted it was not working but stated the office the cabinet was in always remained locked.	01880		

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01880	Continued From page 21 On February 28, 2024, at 8:10 a.m., when the surveyor arrived at licensee's facility the surveyor observed the office door wide open with the medication cabinet door also open. ULP-C was seated at the kitchen table documenting on a tablet and ULP-F was seated on the couch watching television. On February 28, 2024, at 10:47 a.m., HM-C stated all staff are aware they need to observe residents take their medications before returning to other chores. HM-C also stated the office door was open because the ULPs were right there watching it. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *02/26/24*
Time: 07:56:59
Report: 1018241032

Food and Beverage Establishment Inspection Report

Location:
Nagomi Inc
8421 Upland Lane North
Maple Grove, MN55311
Hennepin County, 27

Establishment Info:
ID #: 0037496
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7636078373
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.

Food and Equipment Temperatures

Process/Item: Cold Holding/ HOT DOGS
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: Cold Holding/ DELI MEAT
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: Cold Holding/ MILK
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

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

ESTABLISHMENT DOES ALL SAME DAY SERVICE OF FOOD.

KITCHEN HAS A TWO BASIN SINK FOR DISH WASHING AND HAND WASHING.

DISHWASHER HAS SANITIZE FUNCTION.

FLOORS, WALLS, CEILINGS AND EQUIPMENT OBSERVED TO BE IN GOOD CONDITION.

DISCUSSED PEST CONTROL AND ILLNESS REPORTING.

DISCUSSED ILLNESS REPORTING AND ILLNESS LOG.

Type: Full
Date: *02/26/24*
Time: 07:56:59
Report: 1018241032
Nagomi Inc

Food and Beverage Establishment Inspection Report

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 1018241032 of 02/26/24.

Certified Food Protection Manager: SORAYA SIMONS

Certification Number: FM104977 Expires: 01/14/27

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us