



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 22, 2024

Licensee
Maplewood Homes Of Faribault
428 Northwest 5th Street
Faribault, MN 55021

RE: Project Number(s) SL37568015

Dear Licensee:

On October 1, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 4, 2024, survey and the July 16, 2024, follow-up 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,

A handwritten signature in black ink that reads 'Casey DeVries'.

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

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

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August 9, 2024

Licensee
Maplewood Homes Of Faribault
428 Northwest 5th Street
Faribault, MN 55021

RE: Project Number(s) SL37568015

Dear Licensee:

On July 16, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on April 4, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the April 4, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on April 4, 2024, found not corrected at the time of the July 16, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)

The details of the violations noted at the time of this follow-up survey completed on July 16, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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.

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.

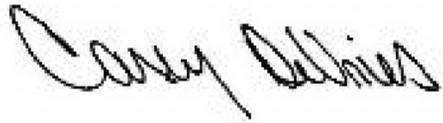
To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

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

Sincerely,

A handwritten signature in black ink that reads "Casey DeVries". The signature is written in a cursive, flowing style.

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37568	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 07/16/2024
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NAME OF PROVIDER OR SUPPLIER MAPLEWOOD HOMES OF FARIBAULT	STREET ADDRESS, CITY, STATE, ZIP CODE 428 NORTHWEST 5TH STREET FARIBAULT, MN 55021
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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
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{0 000}	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS: SL37568015-1</p> <p>On July 16, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on April 4, 2024. At the time of the survey, there were eight residents; eight receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.</p>	{0 000}	<p>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.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>	
{0 470} SS=F	<p>144G.41 Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for</p>	{0 470}		

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

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{0 470}	<p>Continued From page 1</p> <p>determining its staffing level that:</p> <ul style="list-style-type: none"> (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; <p>(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:</p> <ul style="list-style-type: none"> (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; <p>This MN Requirement is not met as evidenced by: No further action required.</p>	{0 470}		
{0 480} SS=F	<p>144G.41 Subd 1 (13) (i) (B) Minimum requirements</p> <p>(13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules,</p>	{0 480}		

Minnesota Department of Health

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{0 480}	Continued From page 2 chapter 4626; and This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{0 485} SS=F	144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) 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; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: No further action required.	{0 485}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	{0 660}		

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{0 660}	Continued From page 3 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action required.	{0 660}		
{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 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	{0 680}		

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{0 680}	Continued From page 4 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: No further action required.	{0 680}		
{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; (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;	{0 780}		

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{0 780}	Continued From page 5 This MN Requirement is not met as evidenced by: No further action required.	{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: No further action required.	{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.	{0 810}		

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{0 810}	<p>Continued From page 6</p> <p>(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.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: No further action required.</p>	{0 810}		
{0 820} SS=D	<p>144G.45 Subd. 2 (g) Fire protection and physical environment</p> <p>(g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to</p>	{0 820}		

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{0 820}	<p>Continued From page 7 correction.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This affected (R)-4 in the bedroom on the upper level.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>During the initial licensing survey, on April 3, 2024, survey staff observed the following items: -It was observed that the occupied bedroom, room #8, on the upper level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 20 inches in height and 23 3/4 inches in width, with a total openable area of 475 square inches. The windows did not meet the minimum requirements for total openable area.</p> <p>-It was observed unoccupied resident bedroom located near kitchen on the main level did not have windows that met the minimum size</p>	{0 820}		

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{0 820}	<p>Continued From page 8</p> <p>requirements for egress escape. The clear openable area of the opened windows measured 18.5 inches in height and 25 inches in width, with a total openable area of 462.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area.</p> <p>On July 16, 2024, at 10:40 a.m., during a facility tour with licensed assisted living director (LALD)-B, the surveyor measured the window in room #8. The window measured 20 inches in width and 43 inches in height, with a total openable area of 860 square inches. This indicated that the window was in current compliance and met minimum requirements.</p> <p>On July 16, 2024, 10:50 a.m., the surveyor observed an unoccupied resident bedroom located near the kitchen on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 18.5 inches in height and 25 inches in width, with a total openable area of 462.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area.</p> <p>On July 16, 2024, at approximately 11:00 a.m., LALD-B and Maintenance (M)-A stated that they had purchased the window, and had intended on replacing this window earlier, but other repairs to the facility ended up taking precedence. The surveyor observed the replacement window in the manufacturer packaging and set in the unoccupied room for installation.</p> <p>No further information was provided.</p>	{0 820}		

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{0 940}	Continued From page 9	{0 940}		
{0 940} SS=C	<p>144G.50 Subd. 2 (e; 5-7) Contract information</p> <p>(5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including:</p> <p>(i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers;</p> <p>(ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b);</p> <p>(iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided;</p> <p>(iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required;</p> <p>(v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent;</p> <p>(vi) a statement that residents may be eligible for assistance with rent through the housing support program; and</p> <p>(vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program;</p> <p>(6) the contact information to obtain long-term care consulting services under section 256B.0911; and</p> <p>(7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.</p>	{0 940}		

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{0 940}	Continued From page 10 This MN Requirement is not met as evidenced by: No further action required.	{0 940}		
{0 950} SS=C	<p>144G.50 Subd. 3 Designation of representative</p> <p>(a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:</p> <p>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.</p> <p>You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."</p> <p>(b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.</p> <p>This MN Requirement is not met as evidenced by:</p>	{0 950}		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER MAPLEWOOD HOMES OF FARIBAULT	STREET ADDRESS, CITY, STATE, ZIP CODE 428 NORTHWEST 5TH STREET FARIBAULT, MN 55021
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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
{0 950}	Continued From page 11 No further action required.	{0 950}		
{01370} SS=E	<p>144G.61 Subd. 2 (a) Training and evaluation of unlicensed person</p> <p>(a) Training and competency evaluations for all unlicensed personnel must include the following:</p> <ul style="list-style-type: none"> (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: <ul style="list-style-type: none"> (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; 	{01370}		

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{01370}	Continued From page 12 (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: No further action required.	{01370}		
{01380} SS=E	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: No further action required.	{01380}		
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter;	{01470}		

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{01470}	<p>Continued From page 13</p> <p>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;</p> <p>(3) handling of emergencies and use of emergency services;</p> <p>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);</p> <p>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;</p> <p>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;</p> <p>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and</p> <p>(9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure.</p> <p>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss</p>	{01470}		

Minnesota Department of Health

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{01470}	Continued From page 14 and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action required.	{01470}		
{01500} SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment;	{01500}		

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{01500}	<p>Continued From page 15</p> <p>disinfecting environmental surfaces; and reporting communicable diseases;</p> <p>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by: No further action required.</p>	{01500}		

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{01650} SS=F	<p>144G.70 Subd. 4 (f) Service plan, implementation and revisions to</p> <p>(f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</p> <p>This MN Requirement is not met as evidenced by: No further action required.</p>	{01650}		
{01700} SS=D	<p>144G.71 Subd. 2 Provision of medication management services</p> <p>(a) For each resident who requests medication management services, the facility shall, prior to</p>	{01700}		

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{01700}	<p>Continued From page 17</p> <p>providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.</p> <p>(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.</p> <p>This MN Requirement is not met as evidenced by: No further action required.</p>	{01700}		
{01750} SS=D	<p>144G.71 Subd. 7 Delegation of medication administration</p> <p>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</p>	{01750}		

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{01750}	Continued From page 18 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: No further action required.	{01750}		
{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: No further action required.	{01890}		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy management For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be	{01940}		

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{01940}	<p>Continued From page 19</p> <p>provided;</p> <p>(2) documentation of specific resident instructions relating to the treatments or therapy administration;</p> <p>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;</p> <p>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and</p> <p>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</p> <p>This MN Requirement is not met as evidenced by: No further action required.</p>	{01940}		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 25, 2024

Licensee
Maplewood Homes of Faribault
428 Northwest 5th Street
Faribault, MN 55021

RE: Project Number(s) SL37568015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 4, 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 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - 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,



Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL37568015-0</p> <p>On April 2, 2024 through April 4, 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 10 residents; 10 receiving services under the Assisted Living license.</p> <p>0820: An immediate order was identified on April 3, 2024. Although the immediacy was lifted on April 4, 2024, non-compliance remains at a level 3/Isolated (G).</p>	0 000	<p>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.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.</p>	
0 470 SS=F	<p>144G.41 Subdivision 1 Minimum requirements</p> <p>(11) develop and implement a staffing plan for determining its staffing level that:</p>	0 470		

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

Minnesota Department of Health

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0 470	<p>Continued From page 1</p> <p>(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;</p> <p>(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</p> <p>(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;</p> <p>(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:</p> <p>(i) awake;</p> <p>(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;</p> <p>(iii) capable of communicating with residents;</p> <p>(iv) capable of providing or summoning the appropriate assistance; and</p> <p>(v) capable of following directions;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee developed and implemented a staffing plan for determining its staffing levels. This had the potential to affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and</p>	0 470		

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0 470	<p>Continued From page 2</p> <p>was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>During the entrance conference on April 2, 2024, at 10:50 a.m. the surveyor requested a copy of the licensee's staffing plan. Licensed assisted living director (LALD)-A stated one direct care staff was scheduled each shift, with a one hour overlap between shifts when two direct care staff were present. Shift hours as follows: Day shift: 7:00 a.m. - 3:00 p.m. Evening shift: 2:00 p.m. - 10:00 p.m. Night shift: 9:00 p.m. - 7:00 a.m. LALD-A was unsure if the licensee had a formal staffing plan.</p> <p>On April 4, 2024, at 11:59 a.m. LALD-A stated she was unable to locate evidence of a staffing plan.</p> <p>The licensee's 4.06 Staffing & Scheduling policy dated August 1, 2021, indicated: 1. The supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.</p>	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	<p>Continued From page 3</p> <p>(13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 2, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> <p>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.</p>	0 480		
0 485 SS=F	<p>144G.41 Subdivision 1. (13)(i)(A)and(C) Minimum Requirements</p> <p>(13) offer to provide or make available at least the</p>	0 485		

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0 485	<p>Continued From page 4</p> <p>following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) 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; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service;</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a menu prepared in advance included all meals and snacks. This had the potential to affect all residents.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee's menu lacked inclusion of the</p>	0 485		
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0 485	<p>Continued From page 5</p> <p>breakfast/lunch meals and snacks.</p> <p>During the facility tour on April 2, 2024, at 11:56 a.m. licensed assisted living director (LALD)-A stated the menu posted for the week of April 1 - 7, 2024, did not include breakfast, lunch or snacks. LALD-A stated breakfast was not posted on the menu as it was a "continental breakfast", and lunch was usually leftovers, a sandwich, or whatever was available at the time; snacks were always available.</p> <p>On April 3, 2024, at 11:49 a.m. R1 stated the licensee only posted the supper meal menu each week. R1 further stated the lunch meal was usually some kind of sandwich and wished there were other options.</p> <p>The licensee's 12.01 Food Service & Menu Planning policy dated August 1, 2021, indicated: 1. Menus will be prepared at least one (1) week in advance and made available to all residents.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 485		
0 660 SS=F	<p>144G.42 Subd. 9 Tuberculosis prevention and control</p> <p>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must</p>	0 660		

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0 660	<p>Continued From page 6</p> <p>include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screen for one of two employees (unlicensed personnel (ULP)-D). This had the potential to affect all current residents living in the facility.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee's TB facility risk assessment dated September 27, 2023, indicated the licensee was a low risk.</p> <p>ULP-D was hired August 3, 2023, to provide direct care services.</p>	0 660		

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0 660	<p>Continued From page 7</p> <p>ULP-D's employee file lacked evidence of a TB symptom screen.</p> <p>On April 4, 2024, at p.m. licensed assisted living director (LALD)-A reviewed ULP-D's employee file and could not find evidence of a TB symptom screen.</p> <p>The licensee's 8.16 Tuberculosis Screening policy dated June 2021, indicated: Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows:</p> <ol style="list-style-type: none"> 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs (health care workers). <p>The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 660		

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0 680 SS=F	<p>144G.42 Subd. 10 Disaster planning and emergency preparedness</p> <p>(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 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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff and visitors at the assisted living facility license.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or</p>	0 680		
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0 680	<p>Continued From page 9</p> <p>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 the residents).</p> <p>The findings include:</p> <p>The licensee's Emergency Preparedness binder last reviewed November 1, 2023, lacked the following required content:</p> <ul style="list-style-type: none"> - an all-hazards risk assessment; and - develop and maintain an EP training and testing program; and - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise. <p>On April 4, 2024, at 11:59 a.m. licensed assistant living director (LALD)-A stated the licensee lacked evidence of the above required content.</p> <p>The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance policy dated August 2, 2021, indicated:</p> <ul style="list-style-type: none"> - The licensee utilized a hazard vulnerability analysis tool to measure threats and hazards of concern, probability of events, measurements 	0 680		

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0 680	<p>Continued From page 10</p> <p>regarding the context of impact on people, property, and business, preparedness, and mitigation.</p> <ul style="list-style-type: none"> - Training - All staff will receive initial training on our emergency preparedness plan, as well as annual refresher training. - Exercises and Drills - The licensee will conduct, at minimum, two emergency preparedness drills every 12 months - these drill to not include required fire/evacuation drills. One annual exercise will be a full-scale community wide exercise. The second annual exercise will either be a second full-scale community wide exercise or a table top exercise focused on our assisted living setting. Exercises and drills will be designed to test our emergency plan and to identify gaps and areas for improvement. <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 680		
0 780 SS=F	<p>144G.45 Subd. 2 (a) (1) Fire protection and physical environment</p> <p>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>(1) for dwellings or sleeping units, as defined in the State Fire Code:</p> <ul style="list-style-type: none"> (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 	0 780		

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0 780	<p>Continued From page 11</p> <p>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;</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so the actuation of one alarm causes all alarms in the facility to actuate. This deficient condition had the ability to affect all staff and residents.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On April 3, 2024, at 1:30 p.m., survey staff toured the facility with the maintenance supervisor (MS)-E and maintenance personnel (MP)-F. During the facility tour, survey staff observed the following items:</p>	0 780		

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0 780	<p>Continued From page 12</p> <p>It was also observed that the resident sleeping rooms were equipped with smoke alarms, but the smoke alarms in the facility were not interconnected, so the actuation of one smoke alarm would cause all other alarms in the facility to actuate.</p> <p>During the interview on April 3, 2024, at 2:00 p.m., MS-E verified the smoke alarms in the facility were not interconnected.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	0 780		
0 800 SS=F	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: The licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive</p>	0 800		

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0 800	<p>Continued From page 13</p> <p>or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On April 3, 2024, at 1:30 p.m., survey staff toured the facility with the maintenance supervisor (MS)-E and maintenance personnel (MP)-F. During the facility tour, survey staff observed the following items in the resident(R)-4 bedroom on the upper level:</p> <p>It was observed that excess material and equipment were stored in the room. The room was filled with electrical equipment, an electric fireplace heater, and household supplies. It was observed that the multiple plug strips were daisy chained to provide power to the electric fireplace and other electrical equipment, creating a possible fire hazard.</p> <p>It was also observed that egress window opening was obstructed by the bed frame and mattress.</p> <p>On April 3, 2024, at 2:00 p.m., during the interview, MS-E stated the resident(R)-4 bedroom on the upper level was not in good repair in regard to resident health and safety in accordance with the maintenance and repair program.</p> <p>Review of the available maintained record, it was also observed that the fire alarm system had not had the required annual maintenance inspection.</p> <p>On April 3, 2024, at 2:00 p.m. during the interview, licensed assisted living director (LALD)-A stated she thought they had the annual fire alarm inspection but could not provide any</p>	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 14 record of the annual inspection. During the interview, LALD-A stated that the record would be provided via email as a follow-up, but no documentation has been provided by follow-up email. 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 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	0 810		

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0 810	<p>Continued From page 15</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to provide the required training. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On April 3, 2024, at 2:30 p.m., licensed assisted living director (LALD)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility.</p> <p>FIRE SAFETY AND EVACUATION PLAN The posted emergency evacuation plan did not show the location and number of resident rooms.</p> <p>The FSEP included the following discrepancies:</p>	0 810		

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0 810	<p>Continued From page 16</p> <ul style="list-style-type: none"> - The FSEP indicated residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility was a residential home and did not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. - The FSEP indicated the system was wired directly to the fire station, and if the system were sounding, the fire department would be on the way. During the interview on April 3, 2024, at 3:00 p.m., MS-E stated the facility installed a fire alarm system, but the system was not wired directly to the fire station. <p>During the interview on April 3, 2024, at 3:00 p.m., LALD-A verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols.</p> <p>TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire.</p> <p>During the interview on April 3, 2024, at 3:00 p.m., LALD-A stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. LALD-A confirmed there was no further documented training for the staff on the fire safety and evacuation plan as required by statute.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 810		

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0 820	Continued From page 17	0 820		
0 820 SS=G	<p>144G.45 Subd. 2 (g) Fire protection and physical environment</p> <p>(g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident(R)-4 in the bedroom on the upper level.</p> <p>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 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:</p>	0 820		

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0 820	<p>Continued From page 18</p> <p>On April 3, 2024, at 1:30 p.m., survey staff toured the facility with the maintenance supervisor (MS)-E and maintenance personnel (MP)-F. During the facility tour, survey staff observed the following items:</p> <p>It was observed that the occupied resident(R)-4 bedroom on the upper level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 20 inches in height and 23 3/4 inches in width, with a total openable area of 475 square inches. The windows did not meet the minimum requirements for total openable area.</p> <p>It was observed unoccupied resident bedroom located near kitchen on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 18.5 inches in height and 25 inches in width, with a total openable area of 462.5 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area.</p> <p>Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to MS-E that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. MS-E verbally confirmed the findings.</p> <p>On April 3, 2024, at 2:00 p.m., during the interview, survey staff explained to MS-E that an</p>	0 820		

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0 820	Continued From page 19 immediate correction order was issued for the above finding. MS-E acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate. Immediacy was lifted on April 4, 2024; however, non-compliance remains at a level 3/Isolated (G).	0 820		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support	0 940		

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0 940	<p>Continued From page 20</p> <p>program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1).</p> <p>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R1 began receiving assisted living services on August 1, 2021.</p> <p>R1's recent Contractual Agreement for Assisted Living Services dated March 3, 2024, lacked the following required content: - a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: - whether the facility is enrolled with the commissioner of human services to provide</p>	0 940		

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0 940	<p>Continued From page 21</p> <p>customized living services under medical assistance waivers;</p> <ul style="list-style-type: none"> - whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); - whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; - whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; - a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; - a statement that residents may be eligible for assistance with rent through the housing support program; and - a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; - the contact information to obtain long-term care consulting services under section 256B.0911; and - the toll-free phone number for the Minnesota Adult Abuse Reporting Center. <p>On April 2, 2024, at 9:20 a.m. licensed assisted living director (LALD)-A stated the contract lacked the above required content. LALD-A further stated the licensee contract would lack the same for all residents.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one</p>	0 940		

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0 940	Continued From page 22 (21) days	0 940		
0 950 SS=C	<p>144G.50 Subd. 3 Designation of representative</p> <p>(a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:</p> <p>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.</p> <p>You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."</p> <p>(b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living</p>	0 950		

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0 950	<p>Continued From page 23</p> <p>contract included the designation of representative statutory language for one of one resident (R1).</p> <p>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R1 began receiving assisted living services on August 1, 2021.</p> <p>R1's recent Contractual Agreement for Assisted Living Services was signed on March 3, 2024.</p> <p>R1's contract and record lacked the following required content:</p> <ul style="list-style-type: none"> - Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of 	0 950		
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0 950	Continued From page 24 attorney ("health care agent"), if applicable." On April 2, 2024, at 9:20 a.m. licensed assisted living director (LALD)-A stated R1's contract and record lacked the required verbatim content as listed above and was unaware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01370 SS=E	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety,	01370		

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01370	<p>Continued From page 25</p> <p>and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of two employees (unlicensed personnel (ULP)-C and ULP-D) to include all required content.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).</p> <p>The findings include:</p> <p>ULP-C ULP-C was hired on January 8, 2021, to provide direct care services to residents of the facility.</p>	01370		

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01370	<p>Continued From page 26</p> <p>On April 4, 2024, at 2:09 p.m. ULP-C was observed administering medications to R4.</p> <p>ULP-D ULP-D was hired on August 3, 2023, to provide direct care services to residents of the facility.</p> <p>ULP-C and ULP-D's employee record lacked documentation of training and competency evaluations for the following topics:</p> <ul style="list-style-type: none"> - reports of changes in the resident's condition to the supervisor designated by the facility; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - understanding appropriate boundaries between staff and residents and the resident's family - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. <p>On April 4, 2024, at 11:59 a.m. licensed assisted living director (LALD)-A stated ULP-C and ULP-D's employee records did not include</p>	01370		

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01370	<p>Continued From page 27</p> <p>evidence of the above training or competencies.</p> <p>The licensee's 5.02 Competency Training Evaluation policy dated August 1, 2021, indicated:</p> <p>5. Training and competency evaluation for all ULP will include:</p> <ul style="list-style-type: none"> b) Reports of changes in the resident's condition to the supervisor designated by the facility d) Maintenance of a clean and safe environment e) Appropriate and safe techniques in personal hygiene and grooming, including: <ul style="list-style-type: none"> i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting f) Training on the prevention of falls g) Standby assistance techniques and how to perform them i) Basic nutrition, meal preparation, food safety, and assistance with eating j) Preparation of modified diets as ordered by a licensed health professional k) Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family m) Understanding appropriate boundaries between staff and residents and the resident's family n) Procedures to use in handling various emergency situations o) Awareness of commonly used health technology equipment and assistive devices. <p>11. A copy of all education, training, and competency testing shall be kept in each employee's personnel file.</p>	01370		

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01370	Continued From page 28 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=E	<p>144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn</p> <p>(b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:</p> <ul style="list-style-type: none"> (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for two of two employees (unlicensed personnel (ULP)-C and ULP-D) to include all required content.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and</p>	01380		

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01380	<p>Continued From page 29</p> <p>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).</p> <p>The findings include:</p> <p>ULP-C ULP-C was hired on January 8, 2021, to provide direct care services to residents of the facility.</p> <p>On April 4, 2024, at 2:09 p.m. ULP-C was observed administering medications to R4.</p> <p>ULP-C's employee record lacked documentation of training and competency for the following topics:</p> <ul style="list-style-type: none"> - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respiration of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the client; - safe transfer techniques and ambulation; - range of motioning and positioning. <p>ULP-D ULP-D was hired on August 3, 2023, to provide direct care services to residents of the facility.</p> <p>ULP-D's employee record lacked documentation of training and competency for the following topics:</p> <ul style="list-style-type: none"> - observing, reporting, and documenting resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other 	01380		

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01380	<p>Continued From page 30</p> <p>observed changes that must be reported to appropriate personnel;</p> <ul style="list-style-type: none"> - reading and recording temperature, pulse, and respiration of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the client; - safe transfer techniques and ambulation; - range of motioning and positioning. <p>On April 4, 2024, at 11:59 a.m. licensed assisted living director (LALD)-A stated ULP-C and ULP-D's employee records did not include evidence of the above training or competencies.</p> <p>The licensee's 5.02 Competency Training Evaluations policy dated August 1, 2021, indicated competency evaluation for unlicensed personnel providing assisted living services must include:</p> <ul style="list-style-type: none"> a. Observing, reporting, and documenting resident status b. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel c. Reading and recording temperature, pulse, and respirations of the resident d. Recognizing physical, emotional, cognitive, and developmental needs of the resident e. Safe transfer techniques and ambulation f. Range of motioning and positioning <p>11. A copy of all education, training, and competency testing shall be kept in each employee's personnel file.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01380		

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01470 SS=F	<p>144G.63 Subd. 2 Content of required orientation</p> <p>(a) The orientation must contain the following topics:</p> <ul style="list-style-type: none"> (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. <p>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research</p>	01470		
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01470	<p>Continued From page 32</p> <p>based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;</p> <p>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one new unlicensed personnel (ULP-D) received orientation to assisted living facility licensing requirements and regulations before providing services.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>ULP-D was hired on August 3, 2023, to provide direct care services for the licensee.</p>	01470		

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01470	<p>Continued From page 33</p> <p>ULP-D's employee records lacked evidence of receiving orientation to assisted living to include the following required content:</p> <ul style="list-style-type: none"> - consumer advocacy services, and; - principles of person-centered planning and service delivery. <p>On April 4, 2024, at 11:59 a.m. licensed assisted living director (LALD)-A stated the above topics were lacking from ULP-D's employee file. LALD-A further stated the facility did not currently have a staff training on principles of person-centered planning/service delivery; however, they were working on implementing one.</p> <p>The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated: Orientation must be completed once for each staff person and is not transferable to another home care provider. The required topics included:</p> <ul style="list-style-type: none"> - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; and, - Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services. <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01470		

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01500 SS=F	<p>144G.63 Subd. 5 Required annual training</p> <p>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:</p> <p>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;</p> <p>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;</p> <p>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this</p>	01500		

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01500	<p>Continued From page 35</p> <p>subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>ULP-C was hired on January 8, 2021, to provide direct care services to residents of the facility.</p>	01500		

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01500	<p>Continued From page 36</p> <p>ULP-C's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - Principles of person-centered planning/service delivery</p> <p>On April 4, 2024, at 11:59 a.m. licensed assisted living director (LALD)-A stated the facility did not currently have a staff training on principles of person-centered planning/service delivery; however, they were working on implementing one.</p> <p>The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated: The following training elements MUST be included every 12 months to all staff who performs direct care services: 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01500		
01650 SS=F	<p>144G.70 Subd. 4 (f) Service plan, implementation and revisions to</p> <p>(f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring</p>	01650		

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01650	<p>Continued From page 37</p> <p>assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan included the required content for one of one resident (R1).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>R1's diagnoses included major depressive</p>	01650		

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01650	<p>Continued From page 38</p> <p>disorder, generalized anxiety, and diabetes.</p> <p>R1's provider orders signed March 28, 2024, included an order for wound care to the right ear three times a week and daily blood sugar monitoring every morning.</p> <p>R1's Individual Service Plan (ISP) dated March 3, 2024, indicated R1 received medication monitoring/management and administration, reminders to complete activities of daily living when needed, behavior monitoring, meals, housekeeping, and laundry. R1's ISP did not include wound care or blood sugar monitoring services. In addition, the ISP did not the schedule and methods of monitoring staff providing services.</p> <p>On April 3, 2024, at 1:59 p.m. clinical nurse supervisor (CNS)-B reviewed R1's ISP and stated R1's treatments had not been included. CNS-B further stated none of the resident's ISPs included the schedule and methods of monitoring staff providing services.</p> <p>The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated: 9. A service plan will include: f. A schedule and method for the next planned monitoring of staff providing services.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01650		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services	01700		

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01700	<p>Continued From page 39</p> <p>(a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.</p> <p>(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management assessment to include all required content for one of one resident (R1), prior to providing medication management services.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a</p>	01700		
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01700	<p>Continued From page 40</p> <p>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).</p> <p>The findings include:</p> <p>During the entrance conference on April 2, 2024, at 10:50 a.m. licensed assisted living director (LALD)-A stated the licensee provided medication management services to the residents of the facility.</p> <p>R1's diagnoses included major depressive disorder, generalized anxiety, and diabetes.</p> <p>R1's Individual Service Plan dated March 3, 2024, indicated R1 received medication monitoring/management and medication administration.</p> <p>R1's prescriber orders signed March 28, 2024, included the following medications: three antidepressants, one antianxiety, two anti-hypertensives, one anticonvulsant utilized for neuropathic pain, two antihyperlipidemics, two supplements, one for hypothyroidism, and three for diabetes.</p> <p>R1's record lacked evidence the RN conducted a face-to-face review of all medications R1 was known to be taking to include interventions to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.</p>	01700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37568	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2024
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NAME OF PROVIDER OR SUPPLIER MAPLEWOOD HOMES OF FARIBAULT	STREET ADDRESS, CITY, STATE, ZIP CODE 428 NORTHWEST 5TH STREET FARIBAULT, MN 55021
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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
01700	<p>Continued From page 41</p> <p>On April 3, 2024, at 1:59 p.m. clinical nurse supervisor (CNS)-B reviewed R1's medication management assessment and stated the required content as noted above had not been included in the assessment.</p> <p>The licensee's 7.01 Medication Management - Assessment, Monitoring & Reassessment policy dated August 1, 2021, indicated: 4) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01700		
01750 SS=D	<p>144G.71 Subd. 7 Delegation of medication administration</p> <p>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.</p>	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37568	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2024
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NAME OF PROVIDER OR SUPPLIER MAPLEWOOD HOMES OF FARIBAULT	STREET ADDRESS, CITY, STATE, ZIP CODE 428 NORTHWEST 5TH STREET FARIBAULT, MN 55021
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01750	<p>Continued From page 42</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-C) followed medication procedures during insulin administration.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R3's diagnoses included diabetes.</p> <p>R3's provider note dated March 13, 2024, included an order for Lantus insulin 65 units once daily.</p> <p>R3's Individual Service Plan dated October 10, 2023, indicated the services included medication administration.</p> <p>On May 2, 2024, at 1:55 p.m., ULP-C was observed preparing R3's opened Lantus SoloStar insulin pen for administration. ULP-C stated R3's opened Lantus insulin pen only had 46 units left; she then obtained another unopened Lantus insulin pen for R1. ULP-C dialed the opened insulin pen to 46 units, then dialed the unopened Lantus insulin pen to 19 units. ULP-C then handed the insulin pens to R3 who was seated at</p>	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37568	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2024
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NAME OF PROVIDER OR SUPPLIER MAPLEWOOD HOMES OF FARIBAULT	STREET ADDRESS, CITY, STATE, ZIP CODE 428 NORTHWEST 5TH STREET FARIBAULT, MN 55021
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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
01750	<p>Continued From page 43</p> <p>the dining room table and explained the two dosages added up to the prescribed 65 units. R3 then proceeded to apply a needle to each insulin pen and administered the medication independently. ULP-C did not prime either Lantus insulin pen prior to dialing up the dosage for administration.</p> <p>On May 2, 2024, at 2:08 p.m. ULP-C stated she didn't prime insulin pens prior to dialing up the dosage, and further stated R3 usually primed her own insulin pen when first opened. ULP-C stated she had dialed the dose each of R3's Lantus pens used for this administration without first priming or offering R3 to do so. ULP-C stated being unaware insulin pens should be primed each time other than when first opened.</p> <p>On April 3, 2023, at 1:59 p.m. clinical nurse supervisor (CNS)-B stated she trained staff to prime insulin pens prior to dialing up the dosage; however, CNS-B further stated she was not the nurse who trained ULP-C as the ULP was hired prior to CNS-B working for the licensee.</p> <p>The Lantus SoloStar pen patient information leaflet titled, How to use your Lantus SoloStar pen, dated 2022, indicated: Step 2. Attach the needle Step 3. Perform a safety test Dial a test dose of 2 units Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test. If no insulin comes out, repeat the test 2 more</p>	01750		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37568	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2024
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01750	Continued From page 44 times. If there is still no insulin coming out, use a new needle and do the safety test again. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
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 and included the date opened of a time-sensitive drug, for two of two residents (R3, 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:	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37568	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2024
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NAME OF PROVIDER OR SUPPLIER MAPLEWOOD HOMES OF FARIBAULT	STREET ADDRESS, CITY, STATE, ZIP CODE 428 NORTHWEST 5TH STREET FARIBAULT, MN 55021
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01890	<p>Continued From page 45</p> <p>R3 R3's diagnoses included diabetes.</p> <p>R3's Individual Service Plan dated October 10, 2024, indicated R1 received medication monitoring/management and medication administration.</p> <p>R3's provider note dated March 13, 2024, included an order for Lantus insulin 65 units subcutaneously (sq) once daily.</p> <p>R4 R4's diagnoses included diabetes.</p> <p>R4's Individual Service Plan dated October 10, 2023, indicated R4 received medication monitoring/management and medication administration.</p> <p>R4's provider orders signed March 7, 2024, included orders for Novolog insulin four units sq bid (twice a day), six units at 5:00 p.m., plus sliding scale twice a day, and Tresiba Flexpen insulin 13 units sq at bedtime.</p> <p>On April 2, 2024, at 2:08 p.m. the surveyor observed the licensee's medication storage cabinet with unlicensed personnel (ULP)-C. The surveyor noted R3 had one open Lantus insulin pen in her medication storage tote, and R4 had one open Novolog insulin pen and one open Tresiba insulin pen in his medication storage tote. None of the three insulin pens had a current original pharmacy label or a date when opened on the pen. ULP-C stated the pharmacy did not provide a label for each individual insulin pen though there was a label on the box the pens came in; these were stored in the refrigerator. ULP-C further stated she never dated the insulin</p>	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37568	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2024
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01890	<p>Continued From page 46</p> <p>pens when opened and was unaware of the requirement.</p> <p>On April 3, 2024, at 1:59 p.m. clinical nurse supervisor (CNS)-B stated the pharmacy did not provide a label for each individual insulin pen and a label was not kept with the opened insulin pens. CNS-B further stated insulin pens should be dated when opened.</p> <p>The Lantus insulin manufacturer's package insert revised June 2023, indicated the Lantus SoloStar 3 mL (milliliter) single-patient use pen expires 28 days after opening.</p> <p>The Tresiba insulin manufacturer's package insert revised December 2016, indicted Tresiba FlexTouch insulin pen expires 56 days after opening.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01890		
01940 SS=D	<p>144G.72 Subd. 3 Individualized treatment or therapy managemen</p> <p>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be</p>	01940		

Minnesota Department of Health

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01940	<p>Continued From page 47</p> <p>provided;</p> <p>(2) documentation of specific resident instructions relating to the treatments or therapy administration;</p> <p>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;</p> <p>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and</p> <p>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>During the entrance conference on April 2, 2024,</p>	01940		

Minnesota Department of Health

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01940	<p>Continued From page 48</p> <p>at 10:50 a.m. licensed assisted living director (LALD)-A stated the licensee provided treatment management services to residents including blood glucose monitoring and wound care.</p> <p>R1's diagnoses included major depressive disorder, generalized anxiety, and diabetes.</p> <p>R1's provider orders signed March 28, 2024, included an order for wound care to the right ear three times a week and daily blood glucose monitoring every morning.</p> <p>R1's Individualized Treatment or Therapy Management Plan dated March 14, 2024, included daily blood glucose monitoring and specific wound care orders three times a week to R1's right ear. The plan indicted a registered nurse (RN) was available 24/7 either in person or by phone for staff to report problems or concerns with treatments or therapy management services. The plan did not include blood glucose parameters or signs/symptoms of potential wound complications to report to the RN.</p> <p>On April 3, 2024, at 1:59 p.m. clinical nurse supervisor (CNS)-B stated R1's treatment plan did not include direction to staff of when to notify a nurse when problems arose with the resident's blood glucose or right ear wound.</p> <p>The licensee's 7.05 Treatment & Therapy Management Plan policy dated August 1, 2021, indicated the licensee will develop and maintain a current individualized treatment and therapy management record for each resident that must include:</p> <p>d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy</p>	01940		

Minnesota Department of Health

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01940	Continued From page 49 services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		



Type: Full
Date: 04/02/24
Time: 11:50:00
Report: 1033241059

Food and Beverage Establishment Inspection Report

Location:

Maplewood Homes of Faribault,
428 5th St. NW
Faribault, MN55021
Rice County, 66

Establishment Info:

ID #: 0006528
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Maplewood Homes of Faribault,

Phone #: 5073344712
ID #: 46422

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

The following orders were issued during this inspection.

4-500 Equipment Maintenance and Operation

4-501.114C3 **** Priority 1 ****

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

Spray bottle was measured at 500PPM.

Comply By: 04/02/24

4-300 Equipment Numbers and Capacities

4-302.14 **** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Facility does not have a quaternary ammonium test kit.

Comply By: 04/16/24

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Quaternary Ammonium: = 500PPM at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: Yes

Food and Equipment Temperatures

Type: Full
 Date: 04/02/24
 Time: 11:50:00
 Report: 1033241059
 Maplewood Homes of Faribault,

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
 Temperature: 0> Degrees Fahrenheit - Location: Freezer
 Violation Issued: No

Process/Item: Cold Holding
 Temperature: 28 Degrees Fahrenheit - Location: Cooler
 Violation Issued: No

Process/Item: Cold Holding
 Temperature: 0> Degrees Fahrenheit - Location: Basement Freezer
 Violation Issued: No

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

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

I acknowledge receipt of the inspection report number 1033241059 of 04/02/24.

Certified Food Protection Manager: Margaret Leigh Clendenin

Certification Number: FM19808 Expires: 12/20/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

Margaret Leigh Clendenin

Signed:  _____

Isaiah Armendariz
 Environmental Health Specialist
 Mankato District Office
 507-344-2743
 isaiah.armendariz@state.mn.us

Food Establishment Inspection Report



No. of RF/PHI Categories Out	1	Date	04/02/24
No. of Repeat RF/PHI Categories Out	0	Time In	11:50:00
Legal Authority MN Rules Chapter 4626		Time Out	

Maplewood Homes of Faribault,	Address 428 5th St. NW	City/State Faribault, MN	Zip Code 55021	Telephone 5073344712
License/Permit # 0006528	Permit Holder Maplewood Homes of Faribault,	Purpose of Inspection Full	Est Type	Risk Category L

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item Mark "X" in appropriate box for COS and/or R

IN= in compliance OUT= not in compliance N/O= not observed N/A= not applicable COS=corrected on-site during inspection R= repeat violation

Compliance Status		COS	R
Supervision			
1	<input checked="" type="radio"/> IN <input type="radio"/> OUT		
PIC knowledgeable; duties & oversight			
2	<input checked="" type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A		
Certified food protection manager, duties			
Employee Health			
3	<input checked="" type="radio"/> IN <input type="radio"/> OUT		
Mgmt/Staff; knowledge, responsibilities & reporting			
4	<input checked="" type="radio"/> IN <input type="radio"/> OUT		
Proper use of reporting, restriction & exclusion			
5	<input checked="" type="radio"/> IN <input type="radio"/> OUT		
Procedures for responding to vomiting & diarrheal events			
Good Hygienic Practices			
6	<input type="radio"/> IN <input type="radio"/> OUT <input checked="" type="radio"/> N/O		
Proper eating, tasting, drinking, or tobacco use			
7	<input type="radio"/> IN <input type="radio"/> OUT <input checked="" type="radio"/> N/O		
No discharge from eyes, nose, & mouth			
Preventing Contamination by Hands			
8	<input checked="" type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/O		
Hands clean & properly washed			
9	<input checked="" type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
No bare hand contact with RTE foods or pre-approved alternate procedure properly followed			
10	<input checked="" type="radio"/> IN <input type="radio"/> OUT		
Adequate handwashing sinks supplied/accessible			
Approved Source			
11	<input checked="" type="radio"/> IN <input type="radio"/> OUT		
Food obtained from approved source			
12	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input checked="" type="radio"/> N/O		
Food received at proper temperature			
13	<input checked="" type="radio"/> IN <input type="radio"/> OUT		
Food in good condition, safe, & unadulterated			
14	<input type="radio"/> IN <input type="radio"/> OUT <input checked="" type="radio"/> N/A <input type="radio"/> N/O		
Required records available; shellstock tags, parasite destruction			
Protection from Contamination			
15	<input checked="" type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Food separated and protected			
16	<input type="radio"/> IN <input checked="" type="radio"/> OUT <input type="radio"/> N/A		
Food contact surfaces: cleaned & sanitized			
17	<input checked="" type="radio"/> IN <input type="radio"/> OUT		
Proper disposition of returned, previously served, reconditioned, & unsafe food			

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input checked="" type="radio"/> N/O		
Proper cooking time & temperature			
19	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input checked="" type="radio"/> N/O		
Proper reheating procedures for hot holding			
20	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input checked="" type="radio"/> N/O		
Proper cooling time & temperature			
21	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input checked="" type="radio"/> N/O		
Proper hot holding temperatures			
22	<input checked="" type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A		
Proper cold holding temperatures			
23	<input checked="" type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Proper date marking & disposition			
24	<input type="radio"/> IN <input type="radio"/> OUT <input checked="" type="radio"/> N/A <input type="radio"/> N/O		
Time as a public health control: procedures & records			
Consumer Advisory			
25	<input type="radio"/> IN <input type="radio"/> OUT <input checked="" type="radio"/> N/A		
Consumer advisory provided for raw/undercooked food			
Highly Susceptible Populations			
26	<input type="radio"/> IN <input type="radio"/> OUT <input checked="" type="radio"/> N/A		
Pasteurized foods used; prohibited foods not offered			
Food and Color Additives and Toxic Substances			
27	<input type="radio"/> IN <input type="radio"/> OUT <input checked="" type="radio"/> N/A		
Food additives: approved & properly used			
28	<input checked="" type="radio"/> IN <input type="radio"/> OUT		
Toxic substances properly identified, stored, & used			
Conformance with Approved Procedures			
29	<input type="radio"/> IN <input type="radio"/> OUT <input checked="" type="radio"/> N/A		
Compliance with variance/specialized process/HACCP			

Risk factors (RF) are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions (PHI)** are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R= repeat violation

Compliance Status		COS	R
Safe Food and Water			
30	<input type="radio"/> IN <input type="radio"/> OUT <input checked="" type="radio"/> N/A		
Pasteurized eggs used where required			
31	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Water & ice obtained from an approved source			
32	<input type="radio"/> IN <input type="radio"/> OUT <input checked="" type="radio"/> N/A		
Variance obtained for specialized processing methods			
Food Temperature Control			
33	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Proper cooling methods used; adequate equipment for temperature control			
34	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input checked="" type="radio"/> N/O		
Plant food properly cooked for hot holding			
35	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input checked="" type="radio"/> N/O		
Approved thawing methods used			
36	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Thermometers provided & accurate			
Food Identification			
37	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Food properly labeled; original container			
Prevention of Food Contamination			
38	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Insects, rodents, & animals not present			
39	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Contamination prevented during food prep, storage & display			
40	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Personal cleanliness			
41	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Wiping cloths: properly used & stored			
42	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Washing fruits & vegetables			

Compliance Status		COS	R
Proper Use of Utensils			
43	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
In-use utensils: properly stored			
44	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Utensils, equipment & linens: properly stored, dried, & handled			
45	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Single-use/single service articles: properly stored & used			
46	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Gloves used properly			
Utensil Equipment and Vending			
47	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Food & non-food contact surfaces cleanable, properly designed, constructed, & used			
48	<input checked="" type="radio"/> X <input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Warewashing facilities: installed, maintained, & used; test strips			
49	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Non-food contact surfaces clean			
Physical Facilities			
50	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Hot & cold water available; adequate pressure			
51	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Plumbing installed; proper backflow devices			
52	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Sewage & waste water properly disposed			
53	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Toilet facilities: properly constructed, supplied, & cleaned			
54	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Garbage & refuse properly disposed; facilities maintained			
55	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Physical facilities installed, maintained, & clean			
56	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Adequate ventilation & lighting; designated areas used			
57	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Compliance with MCIAA			
58	<input type="radio"/> IN <input type="radio"/> OUT <input type="radio"/> N/A <input type="radio"/> N/O		
Compliance with licensing & plan review			

Food Recalls:

Person in Charge (Signature)

Date: 04/04/24

Inspector (Signature)