Electronically Delivered

October 27, 2022

Administrator
Maplewood Homes Of Faribault
519 1st Street Southwest
Faribault, MN 55021

RE: Project Number(s) SL37579015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 23, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500

The total amount you are assessed is $500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

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

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

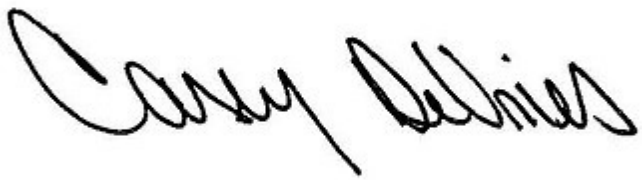
REQUESTING A HEARING

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

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

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

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37579	A. BUILDING: _____ B. WING _____	09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD HOMES OF FARIBAULT	519 1ST STREET SOUTHWEST FARIBAULT, MN 55021

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37579015-0 On September 21, 2022, through September 23, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were eight residents, all of whom received services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care/Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	

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0 250	Continued From page 1	0 250		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250		

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September	0 250		

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0 250	Continued From page 3 21, 2022, at approximately 10:00 a.m., licensed assisted living director (LALD)-B stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will	0 250		

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0 250	Continued From page 4 use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract.	0 250		

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0 250	Continued From page 5 - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by LALD-B on June 10, 2022. The licensee had an assisted living license reissued on August 1, 2022, with an expiration date of September 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: -requirements in section 626.557, reporting of maltreatment of vulnerable adults; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;	0 250		

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0 250	Continued From page 6 - orientation to and implementation of the assisted living bill of rights; - infection control practices; - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks. On September 21, 2022, at 10:00 a.m., LALD-B confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0250, 0430, 0450, 0460, 0470, 0480, 0490, 0510, 0550, 0640, 0650, 0660, 0680, 0780, 0790, 0800, 0810, 0900, 1330, 1440, 1460, 1480, 1500, 1530, 1620, 1650, 1700, 1710, 1730, 1890, and 3090 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services	0 430		

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0 430	Continued From page 7 (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services with the required content for one of one resident (R1). 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). Findings include:	0 430		

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0 430	Continued From page 8 R1's record lacked evidence the licensee provided the resident with a uniform checklist disclosure of services. On September 21, 2022, at 1:50 p.m., licensed assisted living director (LALD)-B stated she did not give R1 or any of the residents a copy of the uniform checklist disclosure of services as she was not aware of the requirement. The licensee's Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) policy, dated August 1, 2021, indicated [The facility] will provide a "Uniform Disclosure of Assisted Living Services and Amenities" (UDALSA) to prospective residents prior to signing an Assisted Living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285;	0 450		

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0 450	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current bill of rights (BOR) for assisted living to one of one resident (R1). 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 the residents). The findings include: R1 admitted for services on October 8, 2009. R1's record lacked evidence R1 had received the assisted living BOR. On September 21. 2022, at 1:50 p.m., licensed assisted living director (LALD)-B stated R1 was not given an updated bill of rights, nor were any of the residents given an updated bill of rights. LALD-B stated she was not aware of the requirement. The licensee's Bill of Rights policy, dated August 1, 2021, indicated [The facility] will provide each resident with the Assisted Living Care Bill of Rights. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		

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0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 460		

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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
0 460	Continued From page 11 The findings include: On September 21, 2022, at 10:00 a.m., licensed assisted living director (LALD)-B stated they do not have a system in place for resident to summon staff 24/7. On September 22, 2022, at 2:25 p.m., LALD-B stated all the residents are independent and ambulatory, therefore are able to summon staff if needed, and she thought a call system was optional. The licensee's undated 24-hour Emergency Response policy indicated residents living at [the facility] have access to 24-hour emergency response by staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (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;	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37579	A. BUILDING: _____ B. WING _____	09/23/2022

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0 470	Continued From page 12 (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the staffing plan was developed as required, potentially affecting the licensee's eight current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). The findings include: The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet	0 470		

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0 470	Continued From page 13 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 - ensured 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. On September 22, 2022, at 2:25 p.m., licensed assisted living director (LALD)-B stated they did not develop a staffing plan and she was not aware of the requirement. The licensee's Staffing & Scheduling policy dated August 1, 2021, indicated the supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the resident's needs 24-hours a day, seven-days a week. The staffing plan will address all requirements as stated above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) 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)	0 480		

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0 480	Continued From page 14 guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect the licensee's eight current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). The findings include: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated September 21, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 490	Continued From page 15	0 490		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities that were based upon individual and group interests or physical, mental, and psychosocial needs. 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	0 490		

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0 490	Continued From page 16 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings included: On September 21, 2022, at 10:00 a.m., during the entrance conference, licensed assisted living director (LALD)-B stated there were daily activities for the residents. On September 21, 2022, at 11:40 a.m., during a tour of the facility, the surveyor observed the common areas and noted the lack of a daily activity schedule posted. On September 22, 2022, at 2:25 p.m., LALD-B stated they have games and activities available, and staff ask residents what they would like to do. LALD-B stated many residents go out for community activities and programs provided through various community programs, and the licensee had not developed an activity program nor did they have a formal schedule of activities posted. The licensee's undated Activity Programming policy indicated on a regular basis, [the facility] will provide a wide range of activities and social recreation for its residents. A monthly calendar will be created and available to all residents. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 490		

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0 510	Continued From page 17	0 510		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 21, 2022, at 9:40 a.m., upon entrance to the facility, the licensee's staff did not	0 510		

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0 510	Continued From page 18 screen the surveyor for COVID-19 nor did the surveyor observe any signage prompting self-screening. In addition, the surveyor observed the lack of eye protection for the unlicensed personnel (ULP) who was in the common area of the house with residents present. On September 21, 2022, at 10:00 a.m., licensed assisted living director (LALD)-B stated their practice was to screen visitors for COVID with a temperature check and screening questions, but it was not documented. LALD-B stated staff likely did not screen the surveyor because they rarely get visitors, and she (the staff) may have thought someone else had done it. LALD-B stated the process was the same for staff, they self-screen, but it also was not documented. LALD-B stated staff screened the residents daily and documented in the resident's records. LALD-B stated they would start wearing eye protection again immediately, she was not aware it was still a requirement. On September 22, 2022, at 8:00 a.m., the surveyor observed ULP-C take temperatures and administer medications to R4, R5, and R6. ULP-C did not perform hand hygiene before, during, or after this process. On September 22, 2022, at 9:40 a.m., LALD-B stated it was the licensee's expectation for staff to wash or sanitize their hands before administering medications and staff has been trained on this. On September 21, 2022, at 2:50 p.m., the surveyor observed the common areas of the facility and noted a lack of signage related to COVID-19. On September 22, 2022, at 3:10 p.m., registered	0 510		

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0 510	Continued From page 19 nurse (RN)-F stated they will add signs throughout the facility regarding COVID-19. The Minnesota Department of Health COVID-19 Personal Protective Equipment (PPE) and Source Control Grids for Congregate Care Settings, by Community Transmission Level dated April 7, 2022, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a facemask and eye protection. The licensee's Infection Control policy dated August 1, 2021, indicated [the facility] infection control program will be consistent with current guidelines from CDC for prevention control in long-term care facilities, where applicable in assisted living facilities. The licensee's undated COVID-19 Preparedness Plan for DHS Licensed Residential Services document indicated all people entering the home will need to go through a screening process which includes taking their temperature & reporting that they have not had any symptoms of COVID-19. The document lacked a statement regarding documentation of screenings for staff and visitors. Additionally, the document indicated, "we have handwashing signs & "cover your cough" signs posted on our medication cabinets as a daily reminder to all staff and residents. Face masks, gloves, & disinfectant are available to all staff and residents as they enter the home, we also have additional PPE available to the staff, if needed, including face shields & gowns." The licensee's undated Procedures for Medication Administration document indicated hands must be washed both before and after administering medications.	0 510		

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0 510	Continued From page 20 The Centers for Disease Control and Prevention (CDC) transmission level tracker dated September 21, 2022, indicated the facility's community transmission level was high. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all of the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 550		

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0 550	Continued From page 21 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). The findings include: The licensee lacked a posting of the grievance procedure, and the name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On September 21, 2022, at 11:40 a.m., the surveyor observed the common areas of the facility and noted there was no required posting of the grievance procedure and contact information for the state and applicable regional Office of the Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On September 22, 2022, at 2:25 p.m., licensed assisted living director (LALD)-B confirmed the required content noted above was not currently posted. LALD-B stated she was not aware of the requirement. The licensee's Complaint/Grievance Posting policy dated August 1, 2021, indicated [the facility] will post, in a conspicuous place, information about our complaint/grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident	0 550		

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0 550	Continued From page 22 complaint/grievances. The posting will also have the contact information for the Office of Ombudsman for Long Term Care and the Ombudsman for Mental Health and Developmental Disabilities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment as required. This had the potential to affect all the licensee's current residents, staff and visitors. This practice resulted in a level two violation (a	0 640		

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0 640	Continued From page 23 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 21, 2022, at 11:40 a.m., the surveyor observed the common areas of the facility and noted there was no required posting of information for reporting suspected crime and maltreatment to include the 911 emergency number and the reporting number for the Minnesota Adult Abuse Reporting Center. On September 22, 2022, at 2:25 p.m. licensed assisted living director (LALD)-B confirmed the required content noted above was not currently posted. LALD-B stated she was not aware of the requirement. The licensee's undated Vulnerable Adult Maltreatment-Prevention & Reporting policy stated, [The facility] would post information for reporting suspected crime and maltreatment. The facility would support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by; a. Posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. b. Posting information and the reporting number for the Minnesota Adult abuse Reporting Center to report suspected maltreatment of a vulnerable adult.	0 640		

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0 640	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease.	0 650		

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0 650	Continued From page 25 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records contained the required content for one of one employee, (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C began employment on June 29, 2018, to provide direct care services to the licensee's residents. ULP-C's employee record lacked the following: -documentation of training for medication administration including competency testing. On September 21, 2022, at 2:30 p.m., ULP-C stated she received medication administration training and had to demonstrate competency. On September 22, 2022, at 2:25 p.m., LALD-B stated training was completed for ULP-C including competency testing for medication administration. LALD-B stated she was not sure why it was not documented in ULP-C's file. The licensee's Employee Record policy dated August 1, 2021, indicated employee records for each person will include: Records of all training	0 650		

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	37579	A. BUILDING: _____ B. WING _____	09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD HOMES OF FARIBAULT	519 1ST STREET SOUTHWEST FARIBAULT, MN 55021

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0 650	Continued From page 26 and in-service education required and/or provided including record of competency testing as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
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 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: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline testing for one of one employee (unlicensed personnel (ULP)-C) and a facility TB risk assessment.	0 660		

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0 660	Continued From page 27 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). The findings include: On September 21, 2022, at 10:00 a.m., licensed assisted living director (LALD)-B stated the licensee had not completed a facility TB risk assessment. ULP-C was hired June 29, 2018, and provided direct cares for residents of the facility. ULP-C's employee record included a TB history and symptom screen dated March 13, 2019, and a PPD (purified protein derivative) which was placed March 13, 2019, with the reading on March 15, 2019. The TB skin test was negative with 0 mm induration. A second step PPD was not completed as required. On September 21, 2022, at 2:25 p.m., LALD-B stated they used to have a facility TB risk assessment, but it had not been updated for several years. LALD-B stated they also do not complete baseline or history and symptom screenings for staff. LALD-B stated they will update the risk assessment and will check with local public health to see if they can assist with Mantoux (a tuberculin skin test to identify TB infection) screenings. The licensee's undated Tuberculosis Screening	0 660		

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0 660	Continued From page 28 policy indicated [the facility] will 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 (MMWR). The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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	0 680		

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0 680	Continued From page 29 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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 680		

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0 680	Continued From page 30 On September 21, 2022, at 1:30 p.m., licensed assisted living director (LALD)-B stated the licensee had not created a disaster or emergency preparedness plan for the facility. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated August 1, 2021, indicated [the facility] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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	0 780		

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0 780	Continued From page 31 operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to confirm that all smoke alarm devices were installed and operational in accordance to MNSFC provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On 09/22/2022 between 09:00 AM to 10:30 AM, survey staff observed in the boiler room a smoke detector mounting plate and associated wiring but the absence of a connected sensing device (M)-D verbally confirmed survey staff observations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		

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0 790	Continued From page 32	0 790		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to confirm inspection and maintenance of fire extinguishers in accordance to MNSFC provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On 09/22/2022 between 09:00 AM to 10:30 AM, survey staff observed on the main floor and in the basement of the structure, fire extinguishers that were last vendor inspected in 2020	0 790		

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0 790	Continued From page 33 (M)-D verbally confirmed survey staff observations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed to maintain the facility in good repair in regards to resident health and safety in accordance with maintenance and repair program. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). Findings include:	0 800		

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0 800	Continued From page 34 1. On 09/22/2022 between 09:00 AM to 10:30 AM, survey staff observed during the walk-through of the structure that three 20# L.P. cylinders were stored in the attached garage 2. On 09/22/2022 between 09:00 AM to 10:30 AM, survey staff observed during the walk-through of the structure the main floor NW bedroom window met horizontal width requirements but not vertical opening requirements for an egress window 3. On 09/22/2022 between 09:00 AM to 10:30 AM, survey staff observed during the walk-through of the structure that the following areas had in use 2-to-6 multi-tap adapter(s): Kitchen, Main Floor NW bedroom, Living Room 4. On 09/22/2022 between 09:00 AM to 10:30 AM, survey staff observed during the walk-through of the structure in the basement SW bedroom an extension cord in use (LALD)-B verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	0 810		

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0 810	Continued From page 35 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 twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, and staff interview, the facility failed have detailed fire safety and evacuation plans and associated confirming documentation. This deficient condition has the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 810		

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0 810	Continued From page 36 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). Findings include: 1. On 09/22/2022 between 09:00 AM to 10:30 AM, survey staff observed that no documentation was presented to confirm that evacuation plan addressed unique and unusual resident needs in the event of an evacuation 2. On 09/22/2022 between 09:00 AM to 10:30 AM, survey staff observed that no documentation was presented to show that annual resident training on evacuation procedures and protocols is being completed 3. On 09/22/2022 between 09:00 AM to 10:30 AM, survey staff observed that no documentation was presented to show that fire drill and/or evacuation drills are being conducted 4. On 09/22/2022 between 09:00 AM to 10:30 AM, survey staff observed that no documentation was presented to show that upon hire and twice annually thereafter that staff are receiving training on fire safety and evacuation 5. On 09/22/2022 between 09:00 AM to 10:30 AM, survey staff observed during documentation review of the fire safety and evacuation plan that staff identified the storage location of the documentation to be the locked med room / closet (LALD)-B verbally confirmed survey staff observations.	0 810		

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0 810	Continued From page 37 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility,	0 900		

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0 900	Continued From page 38 a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to develop and execute an assisted living written contract to include all required content for one of one resident (R1). 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). The findings include: The licensee converted to an Assisted Living license on August 1, 2021. R1 was admitted on October 8, 2009, and began receiving services under the assisted living license on August 1, 2021. R1's contract was dated October 9, 2009. R1's record lacked a written contract from the licensee with the following required content: (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided	0 900		

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0 900	Continued From page 39 directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. On September 22, 2022, at 2:25 p.m., licensed assisted living director (LALD)-B stated she did not have any of the residents sign an updated assisted living contract when the new assisted living licensure came into effect. LALD-B stated she was not aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01330 SS=F	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated	01330		

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01330	Continued From page 40 nursing tasks in an assisted living facility must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personnel (ULP)-C) completed all training and competency evaluations prior to providing delegated nursing tasks to residents. This had the potential to affect all residents receiving assisted living services. 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). The findings include:	01330		

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01330	Continued From page 41 ULP-C's employee record lacked evidence of completed training and demonstrated competency in all the required topics. ULP-C was hired on June 29, 2018, to provide direct care services to licensee's residents. On September 22, 2022, at 8:00 a.m., the surveyor observed ULP-C administer medications to R4, R5, and R6. ULP-C's employee record lacked evidence of training and/or demonstrated competency in the following areas: - 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 - dressing and assisting with toileting - training on the prevention of falls - standby assistance techniques and how to perform them - medication, exercise, and treatment reminders - 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 - awareness of confidentiality and privacy - understanding appropriate boundaries between staff and residents and the resident's family	01330		

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01330	Continued From page 42 - procedures to use in handling various emergency situations - awareness of commonly used health technology equipment and assistive devices - observation, reporting, and documenting resident status - 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 respirations of the resident - recognizing physical, emotional, cognitive, and developmental needs of the resident - safe transfer techniques and ambulation - range of motion and positioning On September 21, 2022, at 2:30 p.m. ULP-C stated she did medication training with the registered nurse and had to demonstrate competency. On September 22, 2022, at 9:10 a.m. licensed assisted living director (LALD)-B stated the ULP's get trained and demonstrate competency to the RN, but there was no documentation of it and this would be the case for all other staff as well. LALD-B stated they only train in the areas that are relevant to their facility and all of the residents are ambulatory and independent with dressing and grooming and all activities of daily living. Licensee's Competency Training Evaluations policy dated August 1, 2021, indicated when a registered nurse or licensed health professional staff of [the facility] delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability	01330		

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01330	Continued From page 43 to competently follow the procedures and perform the tasks. A copy of all education, training, and competency testing shall be kept in each employee's personnel file. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by:	01440		

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01440	Continued From page 44 Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C had a hire date of June 29, 2018. ULP-C's employee record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On September 22, 2022, at 8:00 a.m., the surveyor observed ULP-C performing medication administration for R4, R5, and R6. On September 22, 2022, at 2:25 p.m., licensed assisted living director (LALD)-B stated she was not sure why the RN did not document a 30-day supervision of ULP-C performing a delegated task, it was probably an oversight, and she would make sure it gets done and documented. The licensee's Supervision of Staff-Delegated Services policy dated August 1, 2021, indicated	01440		

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01440	Continued From page 45 direct supervision of staff performing delegated tasks must be provided with 30 calendar days after the date on which the individual begins working for [the facility] and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living licensing requirements and regulations was provided prior to providing assisted living services to residents for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	01460		

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01460	Continued From page 46 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C had a hire date of June 29, 2018, to provide direct care services to the licensee's residents. On September 22, 2022, at 8:00 a.m., the surveyor observed ULP-C administer medications to R6. ULP-C's record lacked evidence orientation was completed for all required topics. On September 22, 2022, at 2:25 p.m., licensed assisted living director (LALD)-B stated she was not aware of the requirements for orientation, but would make sure all staff got up to date with the requirement and documentation added to the employee records. The licensee's Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated all staff of the licensee providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. Orientation must be completed once for each staff person and is not transferable to another "home care provider." Also, the policy directed, "All licensee employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents" and would contain the above listed topics. No further information was provided.	01460		

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01460	Continued From page 47 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
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; disinfecting environmental surfaces; and reporting communicable diseases; (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; (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 (6) the principles of person-centered planning	01500		

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01500	Continued From page 48 and service delivery and how they apply to direct support services provided by the staff person. (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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the 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: Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01500		

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01500	Continued From page 49 The findings include: ULP-C had a start date of June 29, 2018, to provide assisted living services to the licensee's residents. ULP-C's employee training records lacked evidence ULP-C completed annual training as required, in the following areas: - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights - 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 - 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 and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On September 22, 2022, at 2:25 p.m., licensed assisted living director (LALD)-B stated she was not aware of the annual training requirements so all employee records would be lacking the required annual training content. The licensee's Annual Required Staff Training policy dated August 1, 2021, indicated all staff	01500		

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01500	Continued From page 50 performing direct care services would complete at least eight (8) hours of annual training for each 12 months of employment, and must include the following: 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; disinfecting environmental surfaces; and reporting communicable diseases. 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. 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. 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. The policy also indicated the licensee would retain a training record in the employee records to track compliance with annual training requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		

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01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 160 hours worked and two additional hours annually for one of one employee (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a	01530		

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01530	Continued From page 52 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). The findings include: ULP-C was hired on June 29, 2018, to provide services to the licensee's residents. On September 22, 2022, at 8:00 a.m., the surveyor observed ULP-C administer medications to R6. ULP-C's orientation and training record lacked documentation of required dementia training. On September 22, 2022, at 2:25 p.m., licensed assisted living director (LALD)-B stated she was not aware of the requirement for dementia training and none of the staff have had dementia training. The licensee's Dementia Training policy dated August 1, 2021, indicated all staff of [the facility] are required to complete dementia training at the time of hire and annually thereafter. Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01620	Continued From page 53	01620		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed an ongoing reassessment and monitoring using the uniform assessment tool on or before day 90 for one of one resident (R1). 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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37579	A. BUILDING: _____ B. WING _____	09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD HOMES OF FARIBAULT	519 1ST STREET SOUTHWEST FARIBAULT, MN 55021

(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
01620	Continued From page 54 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 21, 2022, at 10:00 a.m., licensed assisted living director (LALD)-B stated the licensee completed initial, 14-day, and 90-day assessments. R1 was admitted on October 8, 2009, and began receiving assisted living services on August 1, 2021. R1's record included a 90-day assessment dated November 18, 2021, a 90-day assessment dated March 24, 2022, 36 days after the assessment was due, and a 90-day assessment dated July 24, 2022, 32 days after the assessment was due. Additionally, R1's 90-day assessments did not include all the required elements on the uniform assessment tool. On September 22, 2022, at 3:10 p.m., registered nurse (RN)-F, stated she was aware the resident assessments needed to be done within 90 days or with a change in condition. RN-F stated she started in July and had been trying to get caught up, however, she was not aware of the uniform assessment tool and would start using it right away. The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required. Resident monitoring and review must be conducted as needed based	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37579	A. BUILDING: _____ B. WING _____	09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD HOMES OF FARIBAULT	519 1ST STREET SOUTHWEST FARIBAULT, MN 55021

(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
01620	Continued From page 55 on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (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	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37579	A. BUILDING: _____ B. WING _____	09/23/2022

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01650	Continued From page 56 chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident service plans included all the required content for one of one resident (R1). 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). The findings include: R1 was admitted on October 8, 2009, and began recieving assisted living services on August 1, 2021. R1's diagnoses included diabetes and schizoaffective disorder. R1's service plan, dated July 31, 2021, indicated R1 received services which included medication administration and behavior management. R1's service plan agreement dated July 31, 2021, lacked the following: - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: - the action to be taken if the scheduled service cannot be provided. On September 22, 2022, at 2:25 p.m., licensed	01650		

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01650	Continued From page 57 assisted living director (LALD)-B stated she did not realize the information was missing, she would need to add the missing content, and update all the resident service plans. The licensee's Service Plan policy dated August 1, 2021, indicated a service plan will include: a schedule and method for the next planned monitoring of staff providing services. A contingency plan that includes action [the facility] will take if scheduled services cannot be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (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. (b) The assessment must identify interventions	01700		

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01700	Continued From page 58	01700		

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.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an assessment to determine what medication management services would be provided and how the medication services would be provided for one of one resident (R1).

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).

The findings include:

R1 admitted to the facility on October 8, 2009, and began receiving assisted living services on August 1, 2021.

R1's service plan dated July 31, 2021, indicated R1 received services to include medication administration and behavior management.

R1's record lacked a medication assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37579	A. BUILDING: _____ B. WING _____	09/23/2022

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01700	Continued From page 59 On September 22, 2022, at 3:10 p.m., registered nurse (RN)-F stated she was not aware of all the requirements that needed to be met regarding medication assessments. The licensee's Medication Management-Assessment, Monitoring & Reassessment policy dated August 1, 2021, indicated [The facility] will, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber conduct an assessment to determine what medication management services will be provided and how the services will be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication re-assessments for one of one resident (R1). This practice resulted in a level two violation (a	01710		

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01710	Continued From page 60 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). The findings include: R1 admitted to the facility on October 8, 2009, and began receiving assisted living services on August 1, 2021. R1's service plan dated July 31, 2021, indicated R1 received services to include medication administration and behavior management. R1's record lacked an annual medication reassessment. On September 22, 2022, at 3:10 p.m., registered nurse (RN)-F stated she was not aware of the requirement. The licensee's Medication Management-Assessment, Monitoring & Reassessment policy dated August 1, 2021, indicated [the facility] will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and at a minimum, annually. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		

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01730	Continued From page 61	01730		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any	01730		

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01730	Continued From page 62 changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete an individualized medication management plan with required content for one of one resident (R1). 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). The findings include: R1 admitted to the facility on October 8, 2009, and began receiving assisted living services on August 1, 2021. R1's service plan dated July 31, 2021, indicated R1 received services to include medication administration and behavior management. R1's record lacked a medication management plan. On September 22, 2022, at 3:10 p.m., registered nurse (RN)-F stated she was not aware of the requirements of the medication management plan.	01730		

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01730	Continued From page 63 The licensee's Medication Management Individualized Plan policy dated August 1, 2021, indicated [The facility] will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: a. A statement describing the medication management services that will be provided b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions c. Documentation of specific resident instructions relating to the administration of medications d. Identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis e. Identification of medication management tasks that may be delegated to unlicensed personnel f. Procedures for staff notifying a registered nurse or appropriate health professional when a problem arises with medication management services, and g. Any resident specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01730		
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	01890		

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01890	Continued From page 64 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 and interview, the licensee failed to dispose of expired medications. 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). The findings include: On September 22, 2022, at 9:50 a.m., the surveyor reviewed the medication cabinets located in a central area of the licensee's facility and observed the following: The following medications were found to be expired: - flucinonide 0.05% topical solution expired October 2020 for R1 - clear lax expired June 2021 for R5 - cetirizine HCl 10 mg expired April 24, 2021 for R6 - albuterol sulfate 90 mcg expired November 2021 for R6 On September 22, 2022, at 3:10 p.m., registered nurse (RN)-F stated they train staff to check expiration dates on the medications they are giving, but there is not a process in place for them to look at other meds such as PRN's (as	01890		

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01890	Continued From page 65 needed). RN-F stated they will add a service for overnight staff to audit medication cabinets for expired medications. They will reeducate staff and ensure supplies such as labels and markers are readily available near the medication cabinets. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a	03090		

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03090	Continued From page 66 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). The findings include: On September 21, 2022, at 9:40 a.m., upon entrance to the facility, the surveyor observed the lack of an electronic monitoring notice to visitors posted. On September 22, 2022, at 2:25 p.m., licensed assisted living director (LALD)-B stated she was not aware of the requirement to post a notice about electronic monitoring. The licensee's undated Electronic Monitoring policy indicated, signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

DEPARTMENT OF HEALTH

Type: Full
Date: *09/21/22*
Time: 12:00:00
Report: 1033221146

Food and Beverage Establishment Inspection Report

Location:
Maplewood Homes of Faribault
519 1st Street SW
Faribault, MN55021
Rice County, 66

Establishment Info:
ID #: 0011833
Risk: Low
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Maplewood Homes of Faribault,

Phone #: 5073324071
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.

7-200 Toxic Supplies and Applications

7-204.11 ** Priority 1 **

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

Facility is not using an approved sanitizer.

Comply By: 09/28/22

Food and Equipment Temperatures

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

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

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

Type: Full
Date: *09/21/22*
Time: 12:00:00
Report: 1033221146
Maplewood Homes of Faribault

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the inspection report number 1033221146 of 09/21/22.

Certified Food Protection Manager: Esther E Tabor

Certification Number: FM89622 Expires: 06/21/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Esther E Tabor

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