DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 8, 2022

Administrator
The Maples At St John
301 South County Road 5
Springfield, MN 56087

RE: Project Number SL25454015

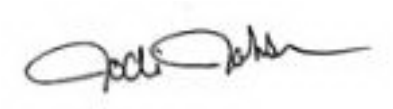
Dear Administrator:

On August 3, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the May 26, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

Electronically Delivered

June 16, 2022

Administrator
The Maples At St John
301 South County Road 5
Springfield, MN 56087

RE: Project Number SL25454015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 26, 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 - $500.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $6,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat.

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

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

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

Sincerely,

Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25454	A. BUILDING: _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MAPLES AT ST JOHN	301 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

(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: SL#25454015 On May 23, 2022, through May 26, 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 24 residents, all of whom recieved services under the provider's Assisted Living license. An immediate correction order was identified on May 25, 2022, issued for SL25454015, tag identification 2310 and 1290. On May 26, 2022, the immediacy of correction orders 2310 and 1290 was removed; however, non-compliance remained at a scope and level of I (level 3, widespread) for correction order 2310, and a scope and levele of G (level 3, isolated) for correction order 1290.	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 Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	

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0 110	Continued From page 1	0 110		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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: On May 23, 2022, at 7:55 a.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A currently held a LALD license effective through October 31, 2022; however, LALD-A's license lacked an organization listed as the Director of Record for the licensee. On May 23, 2022, at 4:05 p.m. LALD-A acknowledged they were not listed as Director of Record with BELTSS and stated they were not	0 110		

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0 110	Continued From page 2 aware they needed to be registered as Director of Record for licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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) 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 and served according to the Minnesota Food Code. This had the potential to affect all residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 480		

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0 480	Continued From page 3 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 24, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program to	0 510		

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0 510	Continued From page 4 comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. This deficient practice 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 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect all staff, residents, and visitors.) The findings include: PERSONAL PROTECTIVE EQUIPMENT/PPE The licensee failed to ensure employees in direct contact with residents were wearing appropriate personal protective equipment (PPE) as per the Centers for Disease Controls (CDC) and Minnesota Department of Health (MDH) guidelines. The Minnesota Department of Health (MDH) document dated April 7, 2022, titled COVID-19 PPE and Source Control Grids for Congregate Care Settings by Community Transmission Level reads: "PPE grid for health care workers, direct service providers (i.e. includes employees, contractors, volunteers, etc.); when community transmission levels are high or substantial, those working with residents without suspected or confirmed SARS-CoV-2 infection should wear a face mask (source control) and eye protection. The document further identified cloth masks were not PPE appropriate for use by health care personnel.	0 510		

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0 510	Continued From page 5 The Centers for Disease Control (CDC) Integrated County View Data Tracker for COVID-19 listed the COVID-19 community transmission rate as "high" for Brown County at the time of the survey. Upon entrance on May 23, 2022, at 10:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A met MDH surveyor at the entrance of the facility. The surveyor screened for signs and symptoms of COVID-19 and was taken by LALD/RN-A to an empty apartment for use as a working space. LALD/RN-A walked the surveyor through the front lobby sitting area where a resident was sitting in a chair doing exercises. LALD/RN-A wore a surgical face mask, but no eye protection. On May 23, 2022, at 11:45 a.m. during facility tour LALD/RN-A and surveyor walked through the dining room where residents were eating, met and spoke to residents in the hallway coming back from lunch, and accompanied a resident on the elevator to 2nd floor. LALD/RN-A wore a surgical face mask, but lacked eye protection. On May 23, 2022, at 2:55 p.m. LALD/RN-A and director of maintenance (DM)-D were observed going in and out of occupied resident rooms with a department of health engineer inspector. Approximately 2-3 minutes were spent inside each resident room. Both LALD-A and DM-D wore a surgical face mask, but lacked eye protection. On May 23, 2022, at 3:00 p.m. unlicensed personnel (ULP)-C was observed wearing a cloth mask and eye protection. When interviewed at this time, ULP-C stated she was not wearing a medical grade mask because the type of face	0 510		

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0 510	Continued From page 6 mask you wore did not matter "just have to have some sort of a mask on" and indicated cloth face masks were acceptable. On May 24, 2022, at 1:00 p.m. LALD/RN-A and surveyor went into R2's room to observe a side rail on the bed. R2 was present in her bedroom with RN-F and ULP-E. LALD/RN-A wore a surgical face mask, but lacked eye protection while in R2's bedroom. On May 25, 2022, at 8:45 a.m. LALD/RN-A stated eye protection must be worn in all residential areas "which is everywhere" unless you are six feet apart in the staff break room or in your own office with no residents present. LALD/RN-A further stated she was aware Brown County was listed as "high" for community transmission rate on the CDC Integrated County View Data Tracker for COVID-19. LALD/RN-A stated she was aware she had not been wearing eye protection stating she had "caught" herself without eye protection, but had been too paper focused with the survey going on. LALD/RN-A further stated staff were to wear medical grade masks. If a cloth mask is worn by a staff member a medical grade mask would need to be underneath it. DISINFECTING EQUIPMENT On May 24, 2022, at 4:14 p.m. ULP-E obtained a plastic storage box kept on the counter in the activity room which contained a communal Assure Prism multi blood glucose machine, lancets, glucometer strips, alcohol pads, and cotton balls. ULP-E and the surveyor went to R1's room where ULP-E washed hands, got supplies ready, and applied gloves. ULP-E cleaned R1's finger using an alcohol pad, used a lancet to obtain a small amount of blood and then	0 510		

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0 510	Continued From page 7 placed a drop of blood on the strip of the glucometer. After the blood glucose test was performed, ULP-E disposed of the lancet in a sharps container, disposed of other used supplies in the garbage including her gloves. ULP-E sanitized hands, documented result, and then reapplied gloves to use an alcohol pad to wipe the glucometer off with. ULP-E was questioned on the disinfection process of the communal glucometer and ULP-E stated the nurses had instructed her to use an alcohol pad to clean and sanitize the glucometer after use. On May 24, 2022, at 4:31 p.m. RN-H stated a pre-moistened alcohol wipe could be used on the communal glucometer to clean and disinfect it. On May 25, 2022, at 8:34 a.m. LALD/RN-A verified the Assure Prism multi blood glucose manufacturer instructions were not being follower for cleaning and disinfecting. LALD/RN-A indicated the licensee had difficulty obtaining the cleaning supplies during the COVID-19 pandemic and had switched the process. LALD/RN-A stated obtaining supplies was no longer an issue and included the blood glucose machine should be cleaned and disinfected per the manufacturer instructions, not with an alcohol wipe. The licensee's Use of Goggles in [the licensee] policy dated November 16, 2021, indicated all staff would wear goggles dependent on the county and community transmission rate. The policy further identified goggles were to be worn in all residential areas, and while providing all care and services unless directed by the LALD or infection preventionist. The licensee's Disinfecting Reusable Equipment and Environmental Surfaces policy dated January	0 510		

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0 510	Continued From page 8 20, 2020, indicated glucometers would be cleaned before and after each use. The policy instructed: using a CaviWipe (disposable ready to use disinfectant wipe), wipe the entire surface of the glucometer and allow to air dry. Take care not to get the strip insertion site damp or moist with disinfectant cleaner. Manufacturer instructions for Assure Prism multi blood glucose monitoring system revised September 2019, included to minimize the risk of transmission of blood-borne pathogens, the cleaning and disinfection procedure should be performed as recommended. The cleaning procedure is needed to clean dirt, blood, and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure is needed to prevent transmission of blood-borne pathogens. Only wipes with Environmental Protection Agency (EPA) registration numbers listed below have been validated for use in cleaning and disinfecting the meter. Any disinfectant product containing these EPA registration numbers may ay be used on this device. Wipes with EPA registrations numbers not listed below should not be used to clean and disinfect the Assure Prism meter. The following disinfectant brand names listed included: Clorox Germicidal Wipes, Dispatch Hospital Cleaner Disinfectant Towels with Bleach, Super Sani-Cloth Germicidal Disposable Wipes and CaviWipes. Guidelines for cleaning and disinfecting the Assure Prism multi blood glucose monitoring system included: -Each time the cleaning and disinfecting procedure is performed, two wipes are needed; one wipe to clean the meter and a second wipe to disinfect the meter. -Always wear the appropriate protective gear,	0 510		

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0 510	Continued From page 9 including disposable gloves. -Open disinfectant package and pull out one towelette. -Squeeze any excess liquid out of the towelette. -Wipe the entire surface of the meter using the towelette at least three times vertically and three times horizontally to clean blood and other body fluids from meter. -Dispose of the towelette. -Repeat above steps with a new towelette to disinfect the meter. -Meter surfaces must remain wet according to contact times listed in the wipe manufacturer's instructions. Once complete, wipe meter dry. -Use caution to not allow moisture to enter the test strip port, data port or battery compartments, as it may damage the meter. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	0 510		
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	0 780		

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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
0 780	Continued From page 10 not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide smoke alarms that are interconnected throughout the facility. This deficient condition had 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: On a facility tour on May 23, 2022, at approximately 2:20 p.m. with Licensed Assisted Living Director/ Registered Nurse (LALD/ RN)-A and Director of Maintenance (DM)-D, it was observed that smoke alarms and smoke detectors were installed in the areas immediately outside the sleeping rooms but were not installed in sleeping rooms as required by statute. An	0 780		

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	25454	A. BUILDING: _____ B. WING _____	05/26/2022

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0 780	Continued From page 11 interview with LALD/ RN-A and DM-D verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810		

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0 810	Continued From page 12 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to provide required employee training on fire safety and evacuation and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on May 23, 2022, at approximately 1:40 p.m. with Licensed Assisted Living Director/ Registered Nurse (LALD/ RN)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. During interview, LALD/ RN-A provided the licensee's policy and stated that employees are provided training on fire safety and evacuation at orientation and annually. Record review of the available documentation	0 810		

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0 810	Continued From page 13 indicated that the licensee did not conduct evacuation drills every other month as required by statute. Review of the provided drill documentation also indicated that the drills conducted did not incorporate evacuation procedures to qualify as an evacuation drill. During interview, LALD/ RN-A stated that licensee had conducted the documented fire drills for the employees but did not incorporate the evacuation procedures and had not conducted them every other month as required. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=G	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a background study was completed prior to staff	01290		

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01290	Continued From page 14 providing services, for one of two employees (unlicensed personnel (ULP)-B) with records reviewed. This resulted in an immediate correction order on May 25, 2022, at approximately 12:37 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B began providing direct care services for the licensee on November 30, 2021. The licensee lacked evidence a background study had been completed prior to ULP-B providing direct care services. On May 23, 2022, at 4:15 p.m. ULP-B was observed to administer a medication to R2. On May 25, 2022, at 11:50 a.m. human resource director (HR)-G stated ULP-B had a background study submitted upon hire and fingerprinting was done on December 7, 2021. HR-G stated a background study clearance is normally received within 48 hours of fingerprints, but confirmed they had never received anything back for ULP-B. HR-G indicated she tracked the background study clearance weekly, but had "probably missed" ULP-B's. On May 25, 2022, at 12:00 p.m. licensed assisted	01290		

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01290	Continued From page 15 living director (LALD)-A verified ULP-B provided unsupervised direct care for residents within the facility. The licensee's Background Checks policy dated February 15, 2022, identified background checks would be conducted on applicants and employees who have routine direct contact with residents or their financial information, and owners who actively participate in operations. Human Resources would conduct the initial background study upon hiring the individual. If a background study is cleared, they would continue with the hiring and orientation process. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On May 26, 2022, at 2:29 p.m. the immediacy of correction order 1290 was removed; however, non-compliance remains at a scope and level of G. TIME PERIOD FOR CORRECTION: Two (2) Days	01290		
01650 SS=D	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;	01650		

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01650	Continued From page 16 (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all the required content for two of three residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1	01650		

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01650	Continued From page 17 On May 24, 2022, at 4:14 p.m. unlicensed personnel (ULP)-E was observed to obtain R1's blood glucose. R1's Service Plan dated January 13, 2022, indicated R1 received services which included medication administration, blood glucose checks, vital signs, bathing, laundry, and housekeeping. The plan noted an individualized initial assessment would be conducted in person by a registered nurse. The initial assessment would be completed within five days after the initiation of home care services. Monitoring and subsequent reassessment would be conducted in the resident's home no more than 14 days after initiation of services. Ongoing monitoring and reassessment would be conducted as needed based on changes in the needs of the resident, but would not exceed 90 days from the last date of the assessment. The monitoring and reassessment would be conducted at the residence or through the utilization of telecommunication methods based on practice standards that meet the individual resident's needs. R1's Service Plan lacked the following: - the correct schedule and methods of monitoring assessments of the resident R2 On May 23, 2022, at 4:15 p.m. ULP-B was observed to administer medications to R2. R2's Service Plan dated October 14, 2020, indicated R2 received medication administration, assistance with compression stockings, laundry, and housekeeping. The plan noted an individualized initial assessment would be conducted in person by a registered nurse. The	01650		

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01650	Continued From page 18	01650		

initial assessment would be completed within five days after initiation of home care services. Monitoring and subsequent reassessment would be conducted in the resident's home no more than 14 days after the initiation of services. Ongoing monitoring and reassessment would be conducted as needed based on changes in the needs of the resident, but would not exceed 90 days from the last date of the assessment. The monitoring and reassessment would be conducted at the residence or through the utilization of telecommunication methods based on practice standards that meet the individual resident's needs.

R2's Service Plan lacked the following:
- the correct schedule and methods of monitoring assessments of the resident

On May 23, 2022, at 3:00 p.m. licensed assisted living director/registered nurse (LALD/RN)-A verified the schedule and methods of monitoring assessments for R1 and R2 was incorrect. LALD/RN-A indicated the service plans were "old" and had previous home care language, not assisted living language for the schedule and methods of monitoring assessments in it. LALD/RN stated a new service plan had been developed and was in their software system, but R1 and R2 did not have updated version yet.

The licensee's Contents of Service Agreement policy dated January 9, 2022, noted the service plan would include the schedule and methods of monitoring assessments.

No further information was provided.

TIME PERIOD FOR CORRECTION:
Twenty-One (21) days.

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01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed for one of three residents (R5) reviewed with medication administration. 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: The licensee's current resident roster identified R5 as receiving medication administration	01760		

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01760	Continued From page 20 services. R5's prescriber's orders dated May 19, 2022, included orders to discharge with current medications from a care facility. The orders included Benefiber powder mix 1 and 1/2 teaspoons with 4-8 ounces of food or liquid, take by mouth once a day. On May 24, 2022, at 8:10 a.m. the surveyor observed unlicensed personnel (ULP)-E prepare R5's medication for administration. ULP-E grabbed the container of R5's Benefiber powder and after comparing the label with R5's electronic medication administration record (eMAR), took a measuring spoon out of cupboard and placed one (1) teaspoon into a cup of water and stirred. The eMAR order was verified by surveyor which identified Benefiber dissolve 1 tablespoonful in 8 ounce of water drink once daily. ULP-E stated the Benefiber was ready to administer when surveyor stopped ULP-E and had her look at measuring spoon again and verify it was a teaspoon, not a tablespoon as ordered. ULP-E called registered nurse (RN) at this time and received direction to give a total of three (3) teaspoons to equal one (1) tablespoon as ordered on eMAR. On May 24, 2022, at 10:45 a.m. licensed assisted living director/registered nurse (LALD/RN)-A verified the current physician order was for Benefiber 1 1/2 teaspoons every day and the order was incorrectly identified on eMAR as 1 tablespoon every day. LALD/RN-A stated R5 had been readmitted to facility following a stay at local care facility, and the Benefiber order had changed while R5 was at the care facility. LALD/RN-A stated the medication should have been reconciled or clarified upon admission back to facility, and confirmed not only had ULP-E	01760		

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01760	Continued From page 21 made a medication error, but it was also a medication transcription error by the nurse processing admission orders. The licensee's Medication Administration / Assistance-Unlicensed Staff policy dated December 26, 2021, noted with medication administration the individual would exercise and prove competence in the following: Right resident Right medication Right dose Right route Right time Right frequency Right form of medication Right reason to administer medication The licensee's Medication Reconciliation policy dated March 28, 2022, noted the most current order by date would be used in the reconciliation of medication orders. If a medication is found to have different doses, routes, frequencies, or any other differentiating information, the RN case manager would reach out for the most recent history and physical from that specific provider and investigate the correct and current order before having the primary care provider sign the new orders. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	02310		

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02310	Continued From page 22 resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical or nursing standards for three of three residents (R2, R6, R7) with bedrails. This resulted in an immediate correction order on May 25, 2022, at 12:55 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnosis included Parkinson's disease. On May 24, 2022, at 8:25 a.m. the surveyor observed a bedrail on the right side near the head of the resident's bed. The bedrail was secured to the bed frame. R2 stated she used the bedrail for transfers in and out of bed, and had been instructed on the risks and benefits of having a bedrail by registered nurse (RN)-F. R2 further included she had never fallen out of bed R2's service plan dated October 14, 2020, indicated R2 received services which included	02310		

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02310	Continued From page 23 medication administration, bathing, assistance with compression stockings, laundry, and housekeeping. R2's quarterly assessment dated March 3, 2022, identified R2 was independent with transfers, toileting, and bed mobility using a grab bar. R2's assessment further indicated the grab bar was monitored daily by staff for safety compliance. R2's record included a Side-Rail Use Assessment & Information Sheet dated May 17, 2022, and indicated R2 had a stationary right grab bar to enhance bed mobility and increase independence. R2's assessment indicated R2 was able to move freely in bed, and get up with the device in place, the bed was at proper height for positioning, mattress fit properly against the device, and the device was firmly attached to the bed/frame. R2's assessment further identified RN-F reviewed the risks versus benefits of the bedrail with the resident; however, the assessment lacked alternatives, cognitive ability, and a description of the bedrail. On May 24, 2022, at approximately 11:36 a.m. licensed assisted living director (LALD)-A observed the bedrail with the surveyor. LALD-A indicated she had assisted in applying the bedrail using the manufacturer instructions that came with it, however, did not keep a copy to consult. LALD-A verified without the manufacturer instructions she would be unable to confirm if R2 was of appropriate age/size/weight and would not know if the bedrail was still installed or being maintained appropriately without them. LALD-A further stated a head or neck would fit through the opening between the bedrail causing a potential for entrapment.	02310		

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02310	Continued From page 24 R6 R6's diagnosis included osteoporosis. R6's service plan dated May 23, 2022, indicated R6 received services including bathing and housekeeping. R6's admission assessment dated May 23, 2022, identified R6 was independent with transfers, toileting, and bed mobility using a grab bar. R6's assessment further indicated the grab bar would be monitored daily by staff. R6's record included a Side-Rail Use Assessment & Information Sheet dated May 23, 2022, and indicated R6 had a right grab bar to increase independence. R6's assessment indicated R6 was able to move freely in bed, and get up with the device in place, the bed was at proper height for positioning, mattress fit properly against the device, and the device was firmly attached to the bed/frame. R6's assessment further identified RN-H reviewed the risks versus benefits of the bedrail with the resident and/or resident's representative; however, the assessment lacked alternatives, cognitive ability, and a description of the bedrail. On May 24, 2022, at approximately 11:40 a.m. LALD-A observed the bedrail with the surveyor present. LALD-A indicated R6 was a new admission and had a bedrail installed by family members over the weekend. LALD-A did not have the manufacturer instructions for the bedrail confirming she would not have a way of know if the bedrail had been installed correctly or of any limitations or safety considerations without them. LALD-A further stated a head or neck would fit through the opening between the bedrail causing a potential for entrapment.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25454	A. BUILDING: _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MAPLES AT ST JOHN	301 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

(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
02310	Continued From page 25 R7 R7's diagnosis included rheumatoid arthritis. R7's service plan dated December 7, 2021, indicated R7 received services including medication administration, bathing, laundry, and housekeeping. R7's quarterly assessment dated March 21, 2022, identified R7 was independent with transfers, toileting, and bed mobility using a grab bar. R7's assessment further indicated there was a protective sleeve that fit over the grab bar, so no gaps or openings were accessible within the grab bar. R7's record included a Side-Rail Use Assessment & Information Sheet dated December 7, 2021, and indicated R7 had a left-sided grab bar used to enhance mobility and increase independence. R7's assessment indicated R7 was able to move freely in bed, get up with the device in place, the bed was at proper height for positioning, mattress fit properly against the device, and the device was firmly attached to the bed/frame. R7's assessment further identified RN-H reviewed the risks versus benefits of the bedrail with the resident and/or resident's representative; however, the assessment lacked alternatives, cognitive ability, and a description of the bedrail. On May 24, 2022, at approximately 11:45 a.m. LALD-A observed the bedrail with the surveyor present. There was a protective mesh covering on the bedrail. LALD-A indicated family had installed the bedrail, and did not have the manufacturer instructions. LALD-A verified she had no way of knowing if the bedrail had been installed correctly or any limitation or safety	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25454	A. BUILDING: _____ B. WING _____	05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MAPLES AT ST JOHN	301 SOUTH COUNTY ROAD 5 SPRINGFIELD, MN 56087

(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
02310	Continued From page 26 considerations with them. The licensee's Bed Side Rails policy dated March 20, 2021, noted when a resident had a side rail, an evaluation for the appropriateness, alternatives, reason for use, and cognitive ability would be documented. In addition, all bed rails would be measured by the RN Case Manager and meet the FDA standards. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bedrails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On May 26, 2022, at 2:29 p.m. the immediacy of correction order 2310 was removed; however, non-compliance remains at a scope and level of I. TIME PERIOD FOR CORRECTION: Two (2) Days	02310		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *05/24/22*
Time: 12:47:28
Report: 1028221099

Food and Beverage Establishment Inspection Report

Location:
The Maples At St John
301 South County Road 5
Springfield, MN56087
Brown County, 08

Establishment Info:
ID #: 0038474
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5077233250
ID #:

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

The following orders were issued during this inspection.

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

Dust build-up on the ceiling in the kitchen area must be removed.

Comply By: 06/14/22

Surface and Equipment Sanitizers

Hot Water: = at 180 Degrees Fahrenheit
Location: Dish Machine - Rinse
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 165 Degrees Fahrenheit - Location: Potatoes
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: Sausage
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -15 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -10 Degrees Fahrenheit - Location: Ambient
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

This Inspection was conducted in conjunction with HRD.

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

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028221099 of 05/24/22.

Certified Food Protection Manager: Kristine Becker

Certification Number: FM44746 Expires: 06/06/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Kristine Becker
Food Service Director

Signed: _____
Ryan Miller
Environmental Health Spec. II
Mankato
Ryan.Miller@state.mn.us