Electronically Delivered

April 4, 2025

Licensee
Maplewood Care Residence
2338 Overlook Circle
Maplewood, MN 55119

RE: Project Number(s) SL25791017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 6, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25791	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE RESIDENCE	2338 OVERLOOK CIRCLE MAPLEWOOD, MN 55119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25791017-0 On March 3, 2025, through March 6, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were five residents; five receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 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 the licensed assisted living director (LALD) was listed with the Board of Executives for Long-term Services and Supports (BELTSS) as the Director of Record (DOR) for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 3, 2025, at 10:15 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated LALD-G was no longer employed with the licensee. In addition, CNS-B stated LALD-H had also left the position a couple of weeks ago. On March 3, 2025, at 11:25 a.m., owner (O)-A stated, via phone, he was currently covering the role of LALD for the facility until someone was hired. O-A stated it was the regulation an owner could cover the LALD position for up to a year and he planned to provide this information to the	0 110		

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0 110	Continued From page 2 surveyor. O-A verbalized he had thirty days from when the previous LALD left employment to apply for a temporary LALD license. LALD-G's last day of employment with licensee was September 5, 2024. LALD-H's last day of employment was February 14, 2025. On March 3, 2025, at 3:45 p.m., director of assisted living and education (DALE)-I of BELTSS stated, via email, "When an LALD leaves, and someone who is not licensed becomes the Director, that person has 30 days to obtain the permit from the date of designation. If the owner is that person, than he has 30 days to obtain the permit and since he was there when the LALD left being the owner, it would be 30 days from that date. Permits are good for 12 months, but he has to be issued a board-issued permit." On March 4, 2025, at 2:59 p.m., DALE-I stated, via email, that they showed no director of record at the facility from 9/5/24 to current, and O-A had not yet applied or registered with the board. The licensee failed to have a LALD listed as DOR with BELTSS from September 5, 2024, until present. On March 5, 2025, at 12:48 p.m., the surveyor updated O-A, via email, the licensee did not have an assigned DOR with BELTSS since September 5, 2024. The Minnesota BELTSS undated website indicated under "Temporary Permit, When the controlling persons of an assisted living	0 110		

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0 110	Continued From page 3 designates an unlicensed individual to be the Permitted Director of Record, the individual must apply for an Assisted Living Director In Residence to secure a permit within 30 days of the date of the designation." No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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; (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	0 470		

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0 470	Continued From page 4 appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop, review, and implement a staffing plan at least twice a year, to determine staffing levels to meet the needs of all residents, potentially affecting all 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, 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: On March 3, 2025, at 11:21 a.m., after the entrance conference, the surveyor requested a copy of the licensee's most current staffing plan, via email. On March 6, 2025, at 8:02 a.m., clinical nurse supervisor (CNS)-B stated she tried to look through the licensee's meeting notes but she was not able to find a documented review of the staffing plan. CNS-B was unaware of the requirement to review the staffing plan at least twice yearly. The surveyor provided education on the staffing plan regulation requirements. The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy dated August 1, 2021,	0 470		

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0 470	Continued From page 5 included "3. A clinical nurse supervisor, or designee, will develop, write, and implement a staffing plan. 4. The staffing plan will provide qualified direct-care staff sufficient to meet the residents' needs 24-hours a day, seven-days a week and will be adequate to address: a. Each resident's needs as identified in the service plan and assisted living contract b. Each resident's acuity level as determined by the most recent assessment or individualized review c. Ability to meet the residents' scheduled and reasonably unforeseeable unscheduled needs given the physical layout of the facility premises d. The staffing plan will indicate if the assisted living has a secured dementia care unit e. Staff competency and training." In addition, included "5. The staffing plan will be evaluated for the appropriately of staffing levels in the facility and revised as needed at a minimum of two times per year." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a	0 480		

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0 480	Continued From page 6 certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and	0 480		

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0 480	Continued From page 7 (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 4, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
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	0 550		

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0 550	Continued From page 8 procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the 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. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. 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, including the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 3, 2025, at 10:45 a.m., the surveyor observed the common area in the main entry of the facility where the postings were located. The	0 550		

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0 550	Continued From page 9 licensee lacked a posted grievance procedure with the current name, telephone number and email contact information for the individual who was responsible for handling resident grievances. On March 3, 2025, at 10:47 a.m., licensed practical nurse (LPN)-C stated the complaint posting contact information was not updated with the correct facility contact and had the previous licensed assisted living director (LALD) information; LPN-C planned to notify clinical nurse supervisor (CNS)-B to get the complaint contact information updated and posted. The licensee's Complaint Policy and Procedure, dated August 1, 2021, indicated "1. Each resident or resident representative receives written notice of our facility ' s process for receiving and resolving complaints. At admission, the designated representative will receive a copy of the complaint policy and process. The complaint policy will be posted in the entrance area. 2. The written notice includes: a. The resident's right to complain to our facility about the services received from our staff; b. The method of submitting a complaint to our facility; and c. A description of the facility ' s complaint resolution process available to residents d. The name and contact information of the person representing the facility designated to handle and resolve complaints. e. The contact information for the Office of Ombudsman for Long-term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints. f. A statement that our facility will not take any action that negatively affects a resident in retaliation for a complaint made or a concern	0 550		

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0 550	Continued From page 10 expressed by the resident or the resident's representative." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must 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:	0 680		

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0 680	Continued From page 11 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, 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: The licensee's Emergency Preparedness Manual title page included, "August 2021: Updated 4/3/2023," indicating the plan was last reviewed on April 3, 2023. The plan lacked evidence of the following requirements: -quarterly review of missing resident policy; and -annual review of the emergency preparedness plan policy. On March 6, 2025, at 8:02 a.m., clinical nurse supervisor (CNS)-B stated she had the resident emergency plans in the licensee's electronic medical record. CNS-B stated she was not aware of the requirement for the emergency preparedness plan to be reviewed annually. CNS-B verbalized she was not aware the missing resident policy was to be reviewed quarterly. The licensee's Missing Resident policy dated August 1, 2021, indicated, "11. The assisted living director and clinical nurse supervisor will review the missing resident plan at least quarterly and	0 680		

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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
0 680	Continued From page 12 document any changes to the plan." The licensee's 9.01 Emergency Preparedness Plan -Appendix Z Compliance policy dated August 1, 2021, included, "[Licensee] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to	01370		

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	25791	A. BUILDING: _____ B. WING _____	03/06/2025

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01370	Continued From page 13 perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed with all required content for one of two employees (unlicensed personnel (ULP)-D). 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On February 10, 2025, at 10:25 a.m., during the	01370		

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01370	Continued From page 14 entrance conference, clinical nurse supervisor (CNS)-B stated initial training, and competency was provided by the licensee's nurse. Also, LALD-A verbalized the licensee's orientation and training was completed in person and they used the Care Fundamentals training program. ULP-D was hired on May 11, 2023, to provide direct care services to residents of the assisted living facility. On March 3, 2025, at 10:58 a.m., the surveyor observed ULP-D assist R2 with medication administration. ULP-D's employee record lacked documentation of training and competency evaluations for all ULP's including: -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; and -understanding appropriate boundaries between staff and residents and the resident's family. On March 6, 2025, at 8:02 a.m., clinical nurse supervisor (CNS)-B stated, via phone, ULP-D missed completing some of the required training content. CNS-B verbalized she planned to follow up with the human resources department to ensure all of the required training were assigned to all unlicensed personnel. The licensee's Assisted Living Orientation - ULP-Staff policy dated August 1, 2021, indicated, "4. Training for ULPs who are not NARs. In addition to training all staff receive, ULPs who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test:	01370		

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01370	Continued From page 15 a. Person-centered care and service delivery including how they apply to direct support services b. Documentation requirements for services provided c. Changes of condition i. Observation ii. How and where to report d. Maintenance of a clean and safe environment e. Appropriate and safe techniques in personal hygiene and grooming f. Fall prevention g. Basic nutrition h. Meal preparation i. Food safety j. Assistance with eating k. Preparation of modified diets as ordered by a licensed health professional l. Communication skills including i. Preserving dignity of the resident ii. Showing respect for the resident, resident preferences, cultural background, and family m. Confidentiality and privacy n. Appropriate boundaries between staff, residents, and resident families o. Commonly used health technology equipment and assistive devices p. Observing, reporting, and documenting resident status q. Basic knowledge of i. Body functioning ii. Changes in body functioning iii. Injuries or other observed changes that must be reported to appropriate personnel r. Recognizing physical, emotional, cognitive and developmental needs of the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01370		

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01370	Continued From page 16 (21) days	01370		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing	01470		

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01470	Continued From page 17 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 the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to include all required content for two of two employees (licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-D). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01470		

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01470	Continued From page 18 The findings include: LPN-C LPN-C was hired November 27, 2024, to provide direct nursing services to residents of the assisted living facility. LPN-C's employee record lacked documentation LPN-C completed the following orientation to Assisted Living topics before providing services: -an overview of the appropriate Assisted Living statutes; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. ULP-D ULP-D was hired on May 11, 2023, to provide direct care services to residents of the assisted living facility. On March 4, 2025, from 8:15 a.m. through 9:12 a.m., the surveyor observed ULP-D assist with direct care of the residents.	01470		

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01470	Continued From page 19 ULP-D's employee record lacked documentation ULP-D completed the following orientation to Assisted Living topics before providing services: -an overview of the appropriate Assisted Living statutes; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On March 6, 2025, at 8:02 a.m., clinical nurse supervisor (CNS)-B stated, via phone call, the licensee's online education program was not allowing her to assign some of the required training courses to LPN-C and ULP-D. CNS-B verbalized she was not able to find evidence LPN-C or ULP-D completed the above listed	01470		

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01470	Continued From page 20 required orientation topics. The licensee's Assisted Living policy dated August 1, 2021, indicated, "At minimum, orientation must include the following topics: a. An overview of Minnesota ' s assisted living law b. An introduction and review of agency policies and procedures related to the provision of assisted living services c. Emergency and disaster training o Handling of emergencies and use of emergency services o Emergency and disaster preparedness plan o Procedures to use in handling various emergency situation d. Employee Right to Know e. The assisted living bill of rights and staff responsibilities to ensuring the exercise and protection of those rights f. Infection control o Bloodborne pathogens o Maintaining a clean and safe environment o TB prevention and control o Basic infection control g. HIPAA / Privacy Practices h. Employee job description i. Organizational chart and roles of staff within the facility j. Principles of person-centered planning and service delivery and how they apply to direct support services k. Types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and providers scope of licensure l. Maltreatment of vulnerable adults m. How to report maltreatment of vulnerable adults n. How to report a crime o Complaint process	01470		

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01470	Continued From page 21 o Handling resident complaints o The facility ' s system for receiving and responding to complaints, o Where and how to report complaints o Contact information for the Office of Health Facility Complaints o Contact information for the Office of the Ombudsman for long-term care o Contact information for the Office of the Ombudsman for Mental Health and Disabilities 3. Quality Management 4. Handling resident ' s finance and property 5. Dementia Training 6. Medicaid Funding a. Medicaid Fraud and Abuse b. Rights - home and community-based services settings rule residential providers." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=E	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	01530		

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01530	Continued From page 22 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 had completed at least eight (8) hours of initial dementia training within 160 working hours of the employment start date for two of two employees (licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-D). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: LPN-C LPN-C was hired November 27, 2024, to provide direct nursing services to residents of the assisted living facility.	01530		

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01530	Continued From page 23 LPN-C's employee record included 2.25 hours of dementia training. The employee record lacked evidence LPN-C completed the required eight hours of dementia training within 160 hours of employment start date. ULP-D ULP-D was hired on May 11, 2023, to provide direct care services to residents of the assisted living facility. On March 4, 2025, from 8:15 a.m. through 9:12 a.m., the surveyor observed ULP-D assist with direct care of the residents. ULP-D's employee record included 2.25 hours of dementia training. The employee record lacked evidence ULP-D completed the required eight hours of dementia training within 160 hours of employment start date. On March 6, 2025, at 8:02 a.m., clinical nurse supervisor (CNS)-B stated, via phone, she was not able to find additional documented dementia training for LPN-C and ULP-D. CNS-B verbalized LPN-C and ULP-D did not have the full eight hours of dementia care training completed within the required time frame of 160 hours on their training transcripts. The licensee's Assisted Living Dementia Training policy dated August 1, 2021, indicated all direct care staff will complete a minimum of 8 hours of initial training on dementia care topics and will be completed within 160 working hours of the employment start date. No further information was provided.	01530		

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01530	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was revised and included a signature or other authentication by the facility and by the resident, or their representative, documenting agreement on the services to be provided for one of one resident (R2).	01640		

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01640	Continued From page 25 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted on September 20, 2018, with diagnoses to include atherosclerotic heart disease, type two diabetes, and history of traumatic brain injury. On March 3, 2025, at 10:58 a.m., the surveyor observed unlicensed personnel (ULP)-D assist R2 with medication administration. On March 4, 2025, from 8:15 a.m. through 9:12 a.m., the surveyor observed ULP-D assist R2 with personal cares and medication administration. R2's initial service plan signed September 18, 2019, indicated R2 received services to include assistance with housekeeping, meals, toileting, bathing, dressing, grooming, nail care, safety checks, vital sign monitoring, catheter care, and medication administration. R2's current Resident Plan of Care, provided March 4, 2025, at 12:42 p.m., indicated R2 received the following additional services not included on the signed service plan: assistance with Bilevel Positive Airway Pressure (BiPAP, for breathing assistance) and mechanical lift transfers. R2's record lacked a service plan with signature to document agreement with the	01640		

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01640	Continued From page 26 revisions. On March 5, 2024, at 3:33 p.m., clinical nurse supervisor (CNS)-B stated, via email, the service plan sent to the surveyor during the survey was the only one they had for R2. Also, CNS-B stated she believed the residents only sign the service plan at admission. On March 6, 2025, at 8:02 a.m., CNS-B stated she was not aware service plan revisions were required to be authenticated by the resident or resident's representative. CNS-B verbalized the facility, resident, or resident's representative did not authenticate R2's service changes. The licensee's Contents of Service Plans policy dated August 1, 2021, indicated, "3. Service plans and any revisions to services plans will have a signature or other authentication by the facility and by the resident. Other authentication could be email confirmation accepting terms of a service agreement or other method deemed appropriate by the assisted living." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25791	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE RESIDENCE	2338 OVERLOOK CIRCLE MAPLEWOOD, MN 55119

(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
01760	Continued From page 27 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 per physician's orders for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 was admitted on September 20, 2018, with diagnoses to include atherosclerotic heart disease (build up of cholesterol plaque in the walls of arteries), type two diabetes, and history of traumatic brain injury. R2's signed initial service plan dated September 18, 2019, indicated R2 received services to include assistance with housekeeping, meals, toileting, bathing, dressing, grooming, nail care, safety checks, vital sign monitoring, catheter care, and medication management.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25791	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE RESIDENCE	2338 OVERLOOK CIRCLE MAPLEWOOD, MN 55119

(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
01760	Continued From page 28 On March 4, 2025, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-D obtain and administer R2's medications from a locked medication cabinet stored in the facility kitchen area. After ULP-D provided medications to R2, ULP-D documented the administration in R2's electronic medication administration record (MAR). R2's medication administration record (MAR) dated February 1, 2025, to February 28, 2025, indicated R2 was to receive medications per R2's provider orders. R2's MAR dated February 2025, lacked documentation of medication administration or refusal of medications for the following dates and times: -February 7, 10, 15, at 2:00 p.m., 4:00 p.m., 5:00 p.m., 7:00 p.m., 8:00 p.m.; -February 16, at 8:00 p.m.; and -February 19, at 8:00 a.m., 9:00 a.m., 10:00 a.m., 12:00 p.m., 2:00 p.m. On March 4, 2025, at 9:46 a.m., licensed practical nurse (LPN)-C stated the licensee recently had some concerns with employees not documenting medication administration as required. LPN-C agreed R2 had some undocumented medications administration as well as no documented reason why the medication was not administered. LPN-C stated the nurses were continuing to educate the staff on the importance of documentation. The licensee's Documentation of Medication, Treatment, and Therapy Management Services policy dated August 1, 2021, indicated, "1. Staff will document each task immediately after that task has been performed. 2. Documentation will follow professional standards for documentation,	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25791	A. BUILDING: _____ B. WING _____	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE RESIDENCE	2338 OVERLOOK CIRCLE MAPLEWOOD, MN 55119

(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
01760	Continued From page 29 including the requirement that entries must be: a. In Rtasks electronic form. b. Date stamped with the time service provided c. Authenticated by logging into your own Rtasks account with username and password. d. Entries in the resident record will never be redacted. If there is an error in an entry, you must note and state the reason in the comment section and let the nurse on duty know." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Follow-Up
Date: *03/20/25*
Time: 10:42:57
Report: 1021251072

Food and Beverage Establishment Inspection Report

Location:
Maplewood Care Residence
2338 Overlook Circle
Maplewood, MN55119
Ramsey County, 62

Establishment Info:
ID #: 0037882
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6125974903
ID #:

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

No NEW orders were issued during this inspection.

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

TODAY'S FOLLOW UP WAS TO ADDRESS AND CLEAR PREVIOUSLY WRITTEN ORDERS FROM A FULL INSPECTION CONDUCTED ON 03/04/25. 7 OUT OF 7 ORDERS WERE CLEARED FROM THE REPORT.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021251072 of 03/20/25.

Certified Food Protection Manager: HEIDI M. KOFSKI

Certification Number: FM117546 Expires: 06/01/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
HEIDI KOFSKI
RN / CFPM

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/04/25*
Time: 13:07:23
Report: 1021251054

Food and Beverage Establishment Inspection Report

Location:
Maplewood Care Residence
2338 Overlook Circle
Maplewood, MN55119
Ramsey County, 62

Establishment Info:
ID #: 0037882
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6125974903
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS FOUND STORED ABOVE READY-TO-EAT SLICED MUSHROOMS, LEMONADE AND STRAWBERRIES IN THE KITCHEN REFRIGERATOR. RAW SHELL EGGS ARE GOING TO BE MOVED TO BOTTOM SHELF TO PREVENT ANY CROSS-CONTAMINATION.

Comply By: 03/04/25

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.

THE CHLORINE ON-SITE WAS NO SPLASH AND IT IS NOT INTENDED FOR FOOD CONTACT SURFACES. STAFF WILL GET APPROVED BLEACH TO USE IN THE KITCHEN. PROVIDE.

Comply By: 03/05/25

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

OBSERVED STAFF USING THEIR FOOD THERMOMETER AND INQUIRED ABOUT HOW THEY SANITIZE THE PROBE. THEY MENTIONED THAT THEY WASHED IT IN THE SINK. DISCUSSED HOW TO PROPERLY SANITIZE FOOD THERMOMETERS. STAFF HAD ALCOHOL WIPES ON-SITE.

Comply By: 03/04/25

6-300 Physical Facility Numbers and Capacities

6-301.12 ***** Priority 2 *****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

NO PAPER TOWELS AT THE KITCHEN HANDWASHING SINK. STAFF PROVIDED PAPER TOWELS DURING INSPECTION. CORRECTED ON-SITE. MAINTAIN A SUPPLY OF PAPER TOWELS DURING ALL HOURS OF OPERATION.

Comply By: 03/04/25

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14D

MN Rule 4626.0285D Provide an approved sanitizing solution for storage of the wet wiping cloths that is free of food debris and visible soil.

WET WIPING FOUND STORED ON THE COUNTER NEXT TO THE KITCHEN SINK. ONCE WIPING CLOTHS ARE WET, THEY NEED TO BE STORED IN AN APPROVED SANITIZER SOLUTION.

Comply By: 03/04/25

3-300C Protection from Contamination: equipment/utensils, consumers

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

A TRAY OF RAW PORK WAS DISCOVERED STORED IN THE KITCHEN REFRIGERATOR DRAWER. THE BOTTOM OF THE DRAWER HAD VISIBLE BLOOD, AND INSIDE, THERE WAS ALSO A SEALED PACKAGE CONTAINING HOT DOGS, BOLOGNA, AND SLICED HAM. SEE COMMENTS.

Comply By: 03/04/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

DUST ACCUMULATION OBSERVED ABOVE THE ELECTRIC STOVE IN THE KITCHEN. CLEAN AND MAINTAIN CLEAN.

Comply By: 03/07/25

Food and Equipment Temperatures

Process/Item: Re-Heating
Temperature: 198 Degrees Fahrenheit - Location: TATOR TOTS - OVEN
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MILK - WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: COTTAGE CHEESE - WHIRLPOOL REFRIGERATOR

Violation Issued: No

Process/Item: Ambient Temperature
Temperature: 39 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: MILK - DOWNSTAIRS REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: DOWNSTAIRS REFRIGERATOR
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH LPN, JESSECA HAGUE AND HEALTH REGULATION DIVISION NURSE EVALUATOR, DEDE HINNENDAEL.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 5 CLIENTS AND THE FACILITY CAN HAVE UP TO 6 CLIENTS.

FOOD IS PREPARED FOR SAME DAY SERVICE.

CONTINUATION OF MN Rule 4626.0300A
STAFF WILL REMOVE THE SEALED PACKAGES OF READY TO EAT FOODS AND THEY WILL SANITIZE THE PACKAGES IN CASE THERE WAS ANY BLOOD CONTAMINATION. DISCONTINUE STORING RAW FOODS WITH READY TO EAT FOODS.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, WOOD FLOORS, POPCORN CEILING, AND WOOD CABINETS. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS.

Type: Full
Date: *03/04/25*
Time: 13:07:23
Report: 1021251054
Maplewood Care Residence

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021251054 of 03/04/25.

Certified Food Protection Manager: HEIDI M. KOFSKI

Certification Number: FM117546 Expires: 06/01/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
JESSECA HAGUE
LPN

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us