DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 27, 2026

Licensee
Boden Senior Living - Maplewood
1700 Beam Avenue
Maplewood, MN 55109

RE: Project Number(s) SL34426016

Dear Licensee:

On November 18, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on September 3, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

CLN

Electronically Delivered

October 13, 2025

Licensee
Boden Senior Living - Maplewood
1700 Beam Avenue
Maplewood, MN 55109

RE: Project Number(s) SL34426016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 3, 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.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34426	A. BUILDING: ______ B. WING ______	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING - MAPLEWOOD	1700 BEAM AVENUE MAPLEWOOD, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34426016-0 On September 2, 2025, through September 3, 2025, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 43 residents; 42 receiving services under the Assisted Living Facility with Dementia Care 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.	
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510		

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(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 infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, 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 the potential to affect a large portion or all of the residents).

The findings include:

On September 3, 2025, at 8:08 a.m., the surveyor observed unlicensed personnel (ULP)-C apply gloves to their hands and assist R2 into the

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0 510	Continued From page 2 shower; R2 was able to shower themselves while sitting on a shower chair. ULP-C changed R2's bed sheets and removed a soiled chux pad (urine absorbent pad). Without removing their gloves, ULP-C applied a new sheet to R2's bed and laid down a new chux pad. ULP-C removed their gloves and applied new ones but did not perform hand hygiene. With soiled gloves, ULP-C assisted R2 out of the shower, dried R2 off then transferred R2 into their wheelchair (w/c) and rolled R2 into their bedroom. ULP-C removed their gloves and applied new ones but did not perform hand hygiene. With soiled gloves, ULP-C assisted R2 to put on a new incontinence brief. ULP-C removed their gloves and applied new ones but did not perform hand hygiene. With soiled gloves, ULP-C applied Goldbond Healing lotion to R2's back and body. Without removing their gloves, ULP-C assisted R2 to put on their shirt and pants; ULP-C removed their gloves and then applied new gloves but did not perform hand hygiene. With soiled gloves, ULP-C assisted R2 to stand using R2's walker. ULP-C applied Prevent silicone cream to R2's bottom and peri area (genital and anal area). Without removing their gloves, ULP-C assisted R2 to pull up their brief; ULP-C removed their gloves but did not perform hand hygiene. With soiled hands, ULP-C handled R2's shirt, jacket, shoes, walker and cologne bottle. With soiled hands, ULP-C then obtained a hairbrush and brushed R2's hair. With soiled hands, ULP-C touched R2's closet door and curtain. With soiled hands, R2 obtained a wet wipe and gave it to R2 to wipe their hands. With soiled hands, ULP-C grabbed R2's w/c handles and wheeled R2 out of their room into the hallway. The surveyor then observed ULP-C remove their gloves and use the hand sanitizer on the medication cart in the hallway; this was	0 510		

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Continued From page 3

the first time ULP-C had performed hand hygiene since beginning R2's cares. With clean hands, ULP-C wheeled R2 to the dining room touching their clean hands to the soiled w/c handles. At 8:44 a.m., the surveyor observed ULP-C return to the medication cart with soiled hands; ULP-C did not perform hand hygiene and began to setup R3's medications in a medication cup. With soiled hands, ULP-C handed the medication cup to R3.

On September 3, 2025, at 8:49 a.m., ULP-C stated they were trained to perform hand hygiene between tasks and after they removed their gloves but was difficult due to the availability of hand sanitizer. ULP-C stated they did not have hand sanitizer on them, but it would be helpful to have a small bottle to put in their pocket. ULP-C stated there were small bottles of hand sanitizer around but they were challenging to find. ULP-C stated the only bottle they had available to them was the large bottle at the medication cart.

On September 3, 2025, at 10:45 a.m., clinical nurse supervisor (CNS)-A and regional director of health services (RDHS)-F both stated their expectation was for ULPs to perform hand hygiene before cares, after glove removal and after cares. RDHS-F stated ULPs recently had a skills training on hand hygiene. Licensed assisted living director (LALD)-D stated ULPs had access to hand sanitizer which was available to be taken with them while providing cares.

The licensee's Hand Hygiene policy last revised in August 2025, indicated alcohol-based hand sanitizer should be used:
-immediately before touching a patient;
-before performing aseptic techniques (indwelling device) or handling an invasive medical device;

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0 510	Continued From page 4 -before moving from a soiled body site to a clean body site on same resident/patient; -after touching a resident/patient or the resident's/patient's immediate environment; -after contact with blood, body fluids or contaminated surfaces; and -immediately before putting on gloves and after glove removal. It further indicated to wash with soap and water: -when hands are visibly soiled; -after caring for a person with known or suspected diarrhea; -after known or suspected exposure to spores (C-diff); and -when caring for a person known or suspected to have norovirus. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced	0 630		

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0 630	Continued From page 5	0 630		

by:
Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) containing required assessment content was completed on admission for one of four residents (R4).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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:

R4 was admitted to the licensee on December 9, 2024, as an independent living (IL) (housing only) resident along with their spouse who received memory care (MC) services.

The licensee's current resident roster, untitled, printed on September 2, 2025, indicated R4 was a resident at the facility.

R4's resident record lacked an IAPP.

On September 2, 2025, at 11:22 a.m., licensed assisted living director (LALD)-D stated they did not complete an IAPP for R4. LALD-D stated R4 was the spouse of a MC resident who lived with their spouse. LALD-D stated they were aware of the requirement, but IL residents were not a common thing for their facility since their entire facility was for MC.

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0 630	Continued From page 6 The licensee's Individualized Abuse Prevention Plan policy revised in July 2021, indicated, "The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of the abuse prevention plan, abuse includes self-abuse." Minnesota Statute Chapter 144G.08 DEFINITIONS. Subd. 59.Resident. "Resident" means an adult living in an assisted living facility who has executed an assisted living contract. 626.5572 DEFINITIONS. Subd. 21.Vulnerable adult. (a) "Vulnerable adult" means any person 18 years of age or older who: (1) is a resident or inpatient of a facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	0 660		

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and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.
(b) The facility must maintain written evidence of compliance with this subdivision.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure an employee's TB test chest Xray (CXR) was completed within 90 days of a documented positive Mantoux skin test or blood test and a symptom screen at the time of hire for one of two employees (unlicensed personnel (ULP)-C).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

The licensee's Facility TB Risk Assessment dated May 12, 2025, indicated the facility was at a low risk level.

ULP-C was hired on September 25, 2024, to provide direct care to residents.

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ULP-C's employee record included a Tuberculosis Skin Test Form dated August 12, 2025, which indicated a purified protein derivative (PPD) (a substance derived from TB bacterium) was administered to ULP-C's right forearm. It further indicated, on August 14, 2025, the result of the Mantoux skin test was an induration (size) of seven millimeters (mm), or a positive test result, however a box for a negative result was checked with a "CHEST XRAY ON FILE."

ULP-C's CXR result dated March 28, 2018, indicated ULP-C did not have active TB.

ULP-C's CXR result dated February 4, 2020, indicated ULP-C did not have active TB.

ULP-C's employee record included a Symptom Screening for Patients with a History of a Positive TB Test Result form dated February 10, 2020.

On September 3, 2025, at 8:08 a.m., the surveyor observed ULP-C perform activities of daily living for R2.

On September 3, 2025, at 9:34 a.m., licensed assisted living director (LALD)-D stated ULP-C's above-mentioned TB Mantoux skin test was positive but was incorrectly marked as negative. LALD-D stated the licensee conducted the TB Mantoux skin test but did not conduct a correlating CXR. LALD-D stated they did not know, to accept a CXR, it needed to be completed within 90 days of the positive TB test. LALD-D stated ULP-C did not have a TB symptom screening completed at the time of hire.

The Minnesota Department of Health TB FAQ dated July 1, 2025, indicated if the health care

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worker had a prior positive TB test result, and they only have the CXR but no other test documentation, then they need to take a new TB test. If the result is positive, a new CXR needs to be completed. The CXR needs to be done within 90 days of the positive test date or dated any time after the positive test date. It further indicated baseline TB screening was required at the time of hire for all health care personnel which included assessment of current active TB symptoms and TB history.

The licensee's TB Infection Control Plan revised May 2024, indicated:
"Screening Health Care Workers
All HCWs should receive baseline TB screening upon hire using a two-step TST or single blood test to test for infection with M. tuberculosis. The following is a list of employees that should be included in screening for tuberculosis. The list may not be all inclusive.
-Administrative Staff
-Chaplain
-Business Office
-Dietary/Food Service
-Nursing Assistants
-Housekeeping
-Maintenance
-Nurses
-Social Workers
-Therapies
-Students
-Volunteers
There are two methods of screening, the TST and the BAMT-blood assay for M. tuberculosis. (Information about each of these methods is available on SharePoint)
All reports of TST or BAMT results as well as any related chest x-ray results are to be maintained in

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0 660	Continued From page 10	0 660		

the employee's personnel record.
TST documentation must include the date and time of the test, the measurement of the test result in mm (millimeters) induration, and an interpretation of the result (positive or negative).
BAMT (blood test), this is the preferred method of testing. Documentation should include the date of the test, the qualitative result (positive, negative, indeterminate etc.), and the quantitative assay (spot count). Positive, intermediate, or borderline results will require further evaluation by a physician.
Health Care Workers should be encouraged to retain copies of their results for future use.
Disregard a health care worker with a history of the BCG vaccination when administering or interpreting a TST.
Baseline TB Screening-HCW:
Baseline screening is required for all health care workers.
Baseline screening consists of three components:
-Assessing for current symptoms of active TB disease
-Assessment of TB history
-Testing for the presence of m-tuberculosis by administering the two-step TST or single BAMT.
An employee may only begin direct care after a negative TB symptom screen and a negative BAMT or 1st step TST. A negative test administered within 90 days of hire is acceptable.
The 2nd-step TST may be done after the HCW begins working."

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING - MAPLEWOOD	1700 BEAM AVENUE MAPLEWOOD, MN 55109

(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
0 775	Continued From page 11	0 775		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 3, 2025, the surveyor toured the facility with maintenance (M)-G, reginal director of operations (RDO)-E, and licensed assisted living director (LALD)-D. The following was observed. 1. All the resident room doors in the facility are rated fire doors with tags on the door frame and hinge side of the door, smoke seal, and closers. It was observed the resident room door closers had been adjusted to no longer close the doors. M-G confirmed the resident rooms closers had been adjusted. Fire doors and smoke and draft	0 775		

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0 775	Continued From page 12 control doors shall not be blocked, obstructed, or otherwise made inoperable. 2. The fire rated doors at the front tv room did not latch when closed. Swinging fire doors shall close from the full-open position and latch automatically. 3. The fire door at the piano room did not close when removed from the magnetic hold open. The floor covering prevent the door from operating. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable. 4. The lock keypads at the main entrance and outside of unit 10 had been damaged and made inoperable. LALD-D stated a resident busted the keypads August 29th and they have not been able to get a contractor to service the keypads because of the holiday weekend. Security devices and locking arrangements in the means of egress that restrict, control, or delay egress shall be maintained. On September 3, 2025, RDO-E, LALD-D, and M-G acknowledged the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and	0 790		

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0 790	Continued From page 13	0 790		

maintained in accordance with the State Fire Code; and

This MN Requirement is not met as evidenced by:
Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors.

This practice resulted in a level one violation (a violation that has no potential to cause more than minimal impact on the client and does not affect health or safety.) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. The fire extinguisher was serviced January of 2025. The only recorded monthly check was 8-11-25. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly by staff.

On September 3, 2025, RDO-E, LALD-D stated they understood the requirements.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7)

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0 790	Continued From page 14 days	0 790		
01540 SS=F	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation 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 staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation 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 provide employees with two hours of initial mental illness and de-escalation training within 80 hours of providing direct care to residents for two of two direct care staff (unlicensed personnel (ULP)-B, ULP-C).	01540		

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01540	Continued From page 15 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 the potential to affect a large portion or all of the residents). The findings include: ULP-B ULP-B was hired on January 21, 2025, to provide direct care to residents. ULP-B's employee record included a Relias (online training platform) transcript printed on September 2, 2025, which indicated ULP-B was assigned, "Mental Health and De-escalation," training due to be completed by June 30, 2025, but the training had not been completed. The licensee's untitled staff schedule for the week of August 31, 2025, through September 6, 2025, indicated ULP-B was scheduled for seven, eight-hour shifts as a full time worker. ULP-C ULP-C was hired on September 25, 2024, to provide direct care to residents. ULP-C's employee record included a Relias (online training platform) transcript printed on September 3, 2025, which indicated ULP-C was assigned, "Mental Health and De-escalation," training due to be completed by June 30, 2025, but the training had not been completed.	01540		

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01540	Continued From page 16 The licensee's untitled staff schedule for the week of August 31, 2025, through September 6, 2025, indicated ULP-C was scheduled for 4, eight-hour shifts as a full time worker. On September 2, 2025, at 11:40 a.m., the surveyor observed ULP-B providing services for multiple residents in the commons area. On September 3, 2025, at 8:08 a.m., the surveyor observed ULP-C perform activities of daily living for R2. On September 3, 2025, at 8:01 a.m., ULP-C stated they think they completed most of their training but there were some trainings they had not completed yet. On September 2, 2025, at 1:20 p.m., licensed assisted living director (LALD)-D stated ULP-B should have completed their scheduled mental health and de-escalation training as scheduled and would follow up with ULP-B immediately. On September 3, 2025, at 9:39 a.m., LALD-D stated ULP-C did not complete their mental health and de-escalation training. LALD-D stated it was a widespread issue for the majority of their employees which needed to be addressed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640		

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01640	Continued From page 17 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 obtain a resident or resident representative's signature documenting agreement on the services to be provided when a change was made to services and the service plan for two of four residents (R3, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	01640		

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than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R3
R3 was admitted to the licensee on June 11, 2025.

R3's current Service Agreement dated August 29, 2025, lacked a signature from the resident or resident representative; it indicated R3 received services for dressing, toileting, bathing, medication management, and meal assistance.

R5
R5 was admitted to the licensee on June 20, 2023.

R5's record lacked a service plan.

R5's Medication Sheet (medication administration record (MAR)) for August and September indicated R5 received services for medication management.

On September 2, 2025, at 10:30 a.m., the surveyor observed the medication refrigerator which included R5's Timolol Maleate Ophthalmic eye drops.

On September 3, 2025, at 8:44 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medication for R3.

On September 3, 2025, at 11:50 a.m., clinical nurse supervisor (CNS)-A stated R3 switched to an elderly waiver and some of their services had

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changed, but they did not get a new service plan signed; they stated obtaining a signature must have been overlooked.

On September 3, 2025, at 1:36 p.m., licensed assisted living director (LALD)-D stated they did not have a signed service plan for R5. LALD-D stated they likely could not find it due to the change of ownership.

The licensee's Service Plan policy dated September 2023, indicated:
"All services provided to clients will be delivered after an assessment by an RN is completed, an up-to date Service Plan is signed by an RN and the client or the client's designated representative.
-Service Addendum to the Assisted Living Contract shall be signed on day of admission
-The home care provider shall finalize a written service plan within 14 days after the initiation of home care services to a client.
-The service plan and any revision must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided."

No further information was provided.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days

01730 SS=D — 144G.71 Subd. 5 Individualized medication management plan — 01730

(a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified

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01730	Continued From page 20 staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing	01730		

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medication management.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure updated medication orders were received and reviewed by the nurse as indicated by the individualized medication plan for one of two residents (R3).

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:

R3 was admitted to the licensee on June 11, 2025.

R3's current Service Agreement dated August 29, 2025, indicated R3 received services for medication management.

R3's Bluestone Physician Services order indicated lovastatin was discontinued on August 13, 2025. Bluestone is an on-site physicians' group who rounds at the facility.

R3's Medication Sheet (medication administration record (MAR)) for August and September indicated R3 was administered lovastatin 80 milligrams (mg) by mouth (PO) daily from August

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13, 2025, through September 2, 2025.

R3's 14-day assessment dated July 16, 2025, indicated R3 required assistance managing prescription medication orders and communication with their provider.

On September 3, 2025, at 8:44 a.m., the surveyor observed unlicensed personnel (ULP)-C administer lovastatin to R3.

On September 3, 2025, at 1:47 p.m., regional director of health services (RDHS)-F stated the Bluestone provider did not send the order to discontinue R3's lovastatin to the pharmacy. RDHS-F stated their process was for Bluestone providers to send order updates to the pharmacy and then the pharmacy notified the facility; since the provider did not send the discontinue order for R3's lovastatin to the pharmacy, it did not get discontinued.

On September 3, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-A stated they did not follow up with R3's Bluestone provider after the provider's visit. CNS-A stated their process was for Bluestone to send order updates to the pharmacy and then pharmacy notified them of order changes; the discontinue order was not sent to the pharmacy so they did not receive a discontinue order.

The licensee's Medication & Treatments policy revised in March 2021, indicated:
"The RN is responsible for assuring:
-current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the tenants' records,
-changes in orders are addressed in the tenant's

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service plan
-changes are communicated to the staff."

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

01880 SS=F — 144G.71 Subd. 19 Storage of medications — 01880

An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to monitor the temperature of their medication storage refrigerator to ensure medications were stored according to manufacturer directions for two of two residents (R5, R6) with refrigerated medications.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the potential to affect a large portion or all of the residents).

The findings include:

R5

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BODEN SENIOR LIVING - MAPLEWOOD	**1700 BEAM AVENUE MAPLEWOOD, MN 55109**

(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
01880	Continued From page 24 R5 was admitted to the licensee on June 20, 2023. R5's record lacked a service plan. R5's Medication Sheet (medication administration record (MAR)) for August and September 2025, indicated R5 received services for medication management and was administered latanoprost ophthalmic solution 0.005% on August 1, 2025, through September 2, 2025. R6 R6 was admitted to the licensee on April 7, 2025. R6's Service Agreement dated April 7, 2025, indicated R6 received blood glucose monitoring, insulin administration, and medication management. R6's MAR for August 2025, indicated R6 was administered Mounjaro 15 milligrams (mg)/0.5 milliliters (ml) on August 6, 13, 27, 2025. The licensee's Refrigerator Temperature Log for September 2025, indicated the "Med room," refrigerator was monitored in the morning and evening; it indicated it had a morning temperature of 44 degrees Fahrenheit (F) on September 2, 2025. On September 2, 2025, at 10:30 a.m., the surveyor observed the medication refrigerator in the medication room with licensed assisted living director (LALD)-D. There was a thermometer connected to the top shelf of the medication refrigerator which indicated the temperature was 55 degrees F; LALD-D stated it indicated 55 degrees as well and went to inform the nurse.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34426	A. BUILDING: ______ B. WING ______	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING - MAPLEWOOD	**1700 BEAM AVENUE MAPLEWOOD, MN 55109**

(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
01880	Continued From page 25	01880		

The medication refrigerator contained the following medications:
-R5's latanoprost ophthalmic solution 0.005%; and
-R6's Mounjaro 15mg/0.5ml.

On September 2, 2025, at 12:34 p.m., clinical nurse supervisor (CNS-A) stated the medication refrigerator had been left ajar earlier in the morning which was why the temperature was so warm. The surveyor observed the medication refrigerator with CNS-A, there was a puddle of water around the base of the refrigerator which had not been there during the prior observation at 10:30 a.m.; the thermometer read 50 degrees F. CNS-A stated they would have maintenance look at the medication refrigerator right away.

On September 3, 2025, at 7:52 a.m., LALD-D stated maintenance was able to fix the medication refrigerator. The surveyor observed the medication refrigerator with LALD-D and the thermometer indicated it had a temperature of 42 degrees F.

The Manufacturer instructions for latanoprost, dated December 2024, indicated unopened bottles should be refrigerated at 36 to 46 degrees F.

The manufacturer instructions for Mounjaro, revised in June 2025, indicated pens should be stored in the refrigerator between 36 to 46 degrees F.

The licensee's Medications & Treatments policy revised in March 2021, indicated, "Medications shall be stored consistent with manufacturer's recommendations (refrigerated, room

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34426	A. BUILDING: ______ B. WING ______	09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING - MAPLEWOOD	**1700 BEAM AVENUE MAPLEWOOD, MN 55109**

(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
01880	Continued From page 26 temperature, or frozen). Store medications in a cool, dry place (25[degrees]C/77[degrees]F) unless specified to be refrigerated." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info	License Info	Inspection Info
BODEN SENIOR LVG - MAPLEWOOD 1700 BEAM AVENUE Maplewood, MN 55109 Ramsey County Parcel: Phone:	License: HFID 34426 Risk: License: Expires on: CFPM: Diana Vazquez CFPM #: 122347; Exp: 3/22/2027	Report Number: F1025251132 Inspection Type: Full - Single Date: 9/2/2025 Time: 1:15 PM Duration: minutes Announced Inspection: Total Priority 1 Orders: 0 Total Priority 2 Orders: 0 Total Priority 3 Orders: 0 Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

No orders issued during inspection
Discussion included foods for highly susceptible populations, cooling (reported not done often, tracked to 70 deg F at 2 hours and placed in WI cooler), testing the internal temperature of the dish machine.
Sticker for ASSE chemical dispenser on the mop sink door frame

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1025251132 from 9/2/2025

Diana

Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

BODEN SENIOR LVG - MAPLEWOOD
Maplewood
County/Group: Ramsey County

Inspection Info

Report Number: F1025251132
Inspection Type: Full
Date: 9/2/2025
Time: 1:15 PM

Food Temperature: **Product/Item/Unit:** Hardboiled egg, pkg**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info
BODEN SENIOR LVG - MAPLEWOOD
Maplewood
County/Group: Ramsey County

Inspection Info
Report Number: F1025251132
Inspection Type: Full
Date: 9/2/2025
Time: 1:15 PM

Sanitizing Equipment: **Product:** Dish machine**; Sanitizing Process:** High temp
Location: Dishwashing Area **Equal To** Degrees F.
Comment: 160 deg F
180 deg F
15 PSI
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:**
Location: 3 compartment sink **Equal To** PPM
Comment: 400 PPM
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1025251132

Food Establishment Inspection Report

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

No. of Risk Factor/Intervention/Violations	0	Date: 9/2/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 1:15 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
BODEN SENIOR LVG - MAPLEWOOD	1700 BEAM AVENUE	Maplewood, MN	55109	

License/Permit #:	Permit Holder:	Purpose of Inspection:	Est. Type:	Risk Category:
HFID 34426		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

#	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/O	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	IN	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

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

GOOD RETAIL PRACTICES

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

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

#			COS	R
	Safe Food and Water			
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
	Food Temperature Control			
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
	Food Identification			
37		Food properly labeled; original container		
	Prevention of Food Contamination			
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		
	Proper Use of Utensils			
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
	Utensils, Equipment and Vending			
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
	Physical Facilities			
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature)

Follow-up: Follow-up Date: