Electronically Delivered

December 12, 2025

Licensee
Carefree Cottages of Maplewood Chateau
1801 Gervais Avenue
Little Canada, MN 55109

RE: Project Number(s) SL31221016

Dear Licensee:

On November 25, 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 11, 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

Electronically Delivered

October 14, 2025

Licensee
Carefree Cottages of Maplewood Chateau
1801 Gervais Avenue
Little Canada, MN 55109

RE: Project Number(s) SL31221016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 11, 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:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31221	A. BUILDING: _____ B. WING _____	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAREFREE COTTAGES OF MAPLEWOOD CHA	1801 GERVAIS AVENUE LITTLE CANADA, 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: SL31221016-0 On September 8, 2025, through September 11, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 194 residents; 71 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (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 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,	0 480		

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0 480	Continued From page 2 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 (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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 9, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee	0 480		

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0 480	Continued From page 3 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 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, interview and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care (OOLTC), and Mental Health and Developmental Disabilities (OOMHDD). 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	0 550		

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0 550	Continued From page 4 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 8, 2025, at 11:01 a.m., during a facility tour of this three-level assisted living facility (ALF), the surveyor observed there was no evidence of the contact information for the state and applicable regional OOLTC and OOMHDD. On September 11, 2025, at 10:01 a.m., licensed assisted living director (LALD)-D stated they were aware that information was to be displayed and believed it might had been taken down. The licensee's 2.10 Complaint/Grievance Posting policy dated August 1, 2021, indicated the licensee would post in a conspicuous place, the contact information for Office of Ombudsman for Long-Term Care, Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints (OHFC). 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	0 680		

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0 680	Continued From page 5 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: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. 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	0 680		

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0 680	Continued From page 6 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 disaster preparedness plan dated January 25, 2025, lacked evidence of the following required content: -subsistence needs for staff and patients; -policies and procedures for sheltering; -policies and procedures for volunteers and; -names and contact information for entities providing services under agreement, residents physicians, and volunteers. On September 11, 2025, at 10:02 a.m., licensed assisted living director (LALD)-D stated they were responsible for the EP Plan for the facility. LALD-D stated they were aware of all the required content for the EP Plan and not recently reviewed the EP Plan for compliance. The licensee's 9.01 Emergency Preparedness Plan - Appendix Z Compliance indicated the licensee EP Plan would be aligned with the Center for Medicare and Medicaid Service State Operation Manual Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=E	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	0 775		

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0 775	Continued From page 7 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 10, 2025, at 11:15 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-D and owner (O)-F. During the tour, the surveyor observed the following: Smoking Material Disposal - On the exterior patio for resident room 143, burnt cigarettes had been disposed of on the ground along the foundation of the building, in an uncovered plastic coffee container stored on the ground, and in an open ashtray on a table. Additionally, one burnt cigarette had been disposed of in the track of the sliding patio door. - In the designated smoking area on the back patio, several burnt cigarettes had been disposed of in the landscaping rocks. The metal bucket used for smoking material disposal also contained plastic and paper.	0 775		

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0 775	Continued From page 8 Building Maintenance - Labeled one hour fire doors were propped open with wedges for the third floor laundry rooms. The wedges were removed during the tour. - Labeled one hour fire doors were propped open with kick down door stops for the second floor library and puzzle rooms. The doors were closed during the tour. - Labeled one hour fire doors were propped open with kick down door stops for the first floor dining room. The doors were closed during the tour. The devices used to hold the labeled fire doors open were not tied to the building fire alarm system in order to release the doors to close automatically in the event of fire alarm activation. Fire-resistant rated doors are required to be maintained as designed and automatically close and latch to protect the path of egress in the corridor in the event of a fire. - In the garage, the ceiling access panel was not installed. Ceilings shall be maintained in order to prevent the passage of smoke or fire. Electrical - To supply power in the CFSS office on the third floor, a yellow extension cord was plugged into a powerstrip and two power strips were daisy chained together. - In resident unit 229, an extension cord was plugged into a multiplug adapter. During the facility tour interview, LALD-D and O-F verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		

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0 780	Continued From page 9	0 780		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This practice resulted in a level two violation (a	0 780		

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0 780	Continued From page 10 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: On September 10, 2025, at 11:15 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-D and owner (O)-F. During the tour, the surveyor observed when smoke alarms were tested by O-F in resident units 111, 137, and 344, the smoke alarms did not test as interconnected. During the facility tour interview, LALD-D and O-F verified the above listed smoke alarm observations. All smoke alarms installed in the dwelling unit must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This 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: On September 10, 2025, at 11:15 a.m., the surveyor toured the facility with licensed assisted living director (LALD)-D and owner (O)-F. During the tour, the surveyor observed the following: - Outside the dining room exit doors, the exterior patio concrete was cracked and uneven, creating a trip/fall hazard. - Several light covers were missing on the exterior of the building. - The window screen was torn for resident unit 141. During the facility tour interview, LALD-D and O-F verified the above listed observations.	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31221	A. BUILDING: _____ B. WING _____	09/11/2025

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CAREFREE COTTAGES OF MAPLEWOOD CHA	1801 GERVAIS AVENUE LITTLE CANADA, MN 55109

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0 800	Continued From page 12 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=D	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 13 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to conduct required drills. 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: On September 10, 2025, licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees every other month evident by a review of fire drill documentation lacking the required frequency. The surveyor requested evacuation drill reports for the period September 2024 to September 2025. Fire drills conducted in 2025 were recorded in January, March, April, May, August, and September. Fire drills conducted in 2024 were recorded in September and December. During an interview on September 10, 2025, at 4:10 p.m., LALD-D verified evacuation fire drills were not conducted in 2025 during June or July	0 810		

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0 810	Continued From page 14 and in 2024 during October or November. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for four of four residents with bed rails (R3, R4, R2, R1). 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: CONSUMER BEDRAILS R3 R3 was admitted to the assisted living facility on May 1, 2024, and began receiving assisted living	02310		

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02310	Continued From page 15 services. R3's Addendum to Contract - Waiver - MN (Minnesota) dated September 20, 2024, indicated R3 received assistance with activities reminder, appointment scheduling, bathing, daily bed making, housekeeping, laundry, behavior management, medication management, and vital signs. R3's diagnoses included hemiplegia and hemiparesis (conditions that cause weakness or paralysis on one of the body, amenia (low blood count of red blood cells), atherosclerosis (buildup of fats in and on the artery walls), benign prostatic hyperplasia (enlarged prostate (gland found in the male reproductive system), bipolar disorder (a condition where persons experiences mood swings), chronic respiratory failure with hypoxia (lungs failing that causes low oxygen in blood cells), dysphagia (difficulty swallowing), dyspnea (difficulty breathing), hypertension, hypernatremia, gastro-esophageal reflux disease (GERD), hypernatremia (high potassium), hyperosmolality, hypernatremia, chronic pain, constipation, paranoid schizophrenia (a condition characterized by persistent delusions, and hallucinations), history of COVID-19, history of nicotine dependence, presence of coronary angioplasty implant and graft (repairs to the heart), sleep apnea, history of falls, shortness of breath, type 2 diabetes, heart failure, and weakness. On September 9, 2025, at 8:20 a.m., the surveyor observed a single consumer bed rail on R3's non-electric, residential-style bed. The bed rail measured 12 inches (") in diameter with a top and bottom section. The top section had three	02310		

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CAREFREE COTTAGES OF MAPLEWOOD CHA	1801 GERVAIS AVENUE LITTLE CANADA, MN 55109

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02310	Continued From page 16 individual slots. The bottom section had four individual slots. Leading from the circular section of the bed rail, was a pole that measured 36" from the top of the circular section to the baseplate. The base of the bed rail was rectangular. Underneath the baseplate was a piece of wood that rested between the baseplate and the floor. The bed rail was securely attached to the bedframe. There were no identifying marks or labels on the bed rail. R3's Assessment dated August 20, 2025, lacked the following required information pertaining to R3's bed rail: -risk vs. benefits discussion (individualized to each resident's risks); -the resident's preferences; -any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; and -documentation the Consumer Product Safety Commission (CPSC) was reviewed for recalls. R3's assessment indicated the bed rail was installed per manufacturer's instructions and was in good condition. The manufacturer's instructions in R3's record indicated the Halo bed rail should be installed to an adjustable section of a hospital bed and could be connected to the other side of the adjustable section of the bed. The instructions did not include directions for applying the bed rail to a consumer bed and did not include the same equipment found in R3's room, i.e., pole to floor and baseplate. The bed rail instructions made available to the surveyor from R3's record did not match the type of equipment being used to install the bed rail to R3's bed.	02310		

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02310	Continued From page 17 On September 10, 2025, at 7:00 a.m., the surveyor conducted an internet search for Halo bed rail installation instructions. The surveyor reviewed the Halo Mobility Solutions manufacturer's instruction dated November 2020 which appeared to represent the equipment in R3's room. The instructions included direction to attach to a regular bedframe with the baseplate being adjustable to meet the floor. The manufacturer's instructions did not indicate to use a piece of wood between the baseplate and the floor. R4 R4 was admitted to the assisted living facility on November 29, 2017, and began receiving assisted living services. R4's Addendum to Contract - Waiver - MN (Minnesota) indicated R4 received assistance with laundry, bathing, dressing, housekeeping, behavior management, medication management, and vital signs. R4's diagnoses included traumatic brain injury (damage to the brain), anemia, GERD, heart murmur (abnormal sounds coming from the heart), and peripheral vascular disease (a condition that affects blood vessels in the exterminates. On September 9, 2025, at 8:30 a.m., the surveyor observed bilateral consumer bed rails on R4's non-electric, residential-style bed. Both bed rails measured 12" in diameter with a top and bottom section. The top section had three individual slots. The bottom section had four individual slots. Both bed rails were loose. There were no identifying marks or labels on the bed	02310		

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02310	Continued From page 18 rails. R4's Assessment dated July 15, 2025, lacked the following required information pertaining to the bed rails: -the resident's bed rail use/need assessment; -the resident's preferences; -installation and use according to manufacturer's guidelines; -physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; -any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; and -documentation the CPSC was reviewed for recalls. R2 R2 was admitted to the assisted living facility on October 2, 2023, and began receiving assisted living services. R2's diagnoses included cerebrovascular disease (a disease that affects the blood vessels supplying the brain, causing reduced oxygen to the brain), depression, dysarthria and anarthria (speech disorder that affects the muscles involved in speech), hypertension (high blood pressure), hypokalemia (low potassium), idiopathic progressive neuropathy disease (generalized pain in nerves), malignant neoplasm of the upper-outer quadrant of left breast (cancer in the breast), muscle weakness, disease of the stomach, atrial fibrillation (abnormal heart beat), radiculopathy in the lumber region (compressed nerves in the lower park of the back), and type II diabetes (process where the body cannot regular blood sugars).	02310		

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02310	Continued From page 19 R2's Addendum to Contract - Waiver - MN (Minnesota) dated April 4, 2025, indicated R2 received assistance with activities reminder, housekeeping, laundry, linen exchange, and medication management. On September 9, 2025, at 8:35 a.m., the surveyor observed bilateral consumer bed rails on R2's electric adjustable bed. The bed rails were a square shaped and measured 8" by 8". The top portion consisted of three sections. The first and last section were an irregular shape, and the middle section was a "V" shape. Both bed rails were clamped to the bedframe but were loose. There were no identifying marks or labels on the bed rails. R2's Assessment dated August 7, 2025, lacked the following required information pertaining to R2's bed rails: -the resident's preferences; -installation and use according to manufacturer's guidelines; and -documentation the CPSC was reviewed for recalls. HOSPITAL BED RAILS R1 R1 was admitted to the assisted living facility on January 23, 2025, and began receiving assisted living services. R1's diagnoses included spondylosis (tingling, numbness in the arms, hands, legs and arms), cervalgia (pain in the upper part of the back), disorder of the adrenal gland (a gland that secretes hormones to various bodily functions,	02310		

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02310	Continued From page 20 hypertension, history of falling, hypercalcemia (high calcium content in the blood), hyperosmolality (higher content of solutes (nutrition in the body), hypernatremia (high sodium (salt) in the blood), hyperparathyroidism (on over active thyroid gland (gland that regulates metabolic processes (cell functions), insomnia (difficultly staying asleep), long term use of insulin (a medication that helps regulate blood sugars), hyperlipidemia (high cholesterol), obesity (large body mass), obstructive sleep apnea (brief periods of not breathing while sleeping), generalized arthritis (inflammation in joints resulting in pain), type II diabetes, and vitamin D deficiency. R1's Addendum to Contract - Waiver - MN (Minnesota) dated March 18, 2025, indicated R1 received assistance with laundry, activity reminder, appointment scheduling, bathing, dressing and grooming, escorts, housekeeping, linen exchange, medication management, personal assistance, toileting, and transfer assistance. On September 9, 2025, at 8:10 a.m., the surveyor observed bilateral hospital bed rails on R1's electric adjustable bed. The bed rails had an identifying label that read, "MDS89697." There were three main sections to both bed rails. Starting from the left side of the rail, there were two areas that measured 3.5" each with a height of 12". The next area had five sections that measured 2.5" each in length with a height of 18". The next area had two sections that measured 3.5" in length with a height of 12". Both bed rails were firmly attached to the bed. R1's Assessment dated July 7, 2025, lacked the	02310		

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02310	Continued From page 21 following required information: -the resident's preferences; and -installation and use according to manufacturer's guidelines. On September 9, 2025, at 8:35 a.m., clinical nurse supervisor (CNS)-C stated the registered nurse (RN) was responsible for the bed rail assessments. CNS-C stated for R3, the missing information was not included in the assessment, and they were unaware of the requirement. CNS-C stated for R4, they did not have the manufacturer's instructions or any of the missing required information and was not aware of all the requirements. CNS-C stated for R2, they did not have the manufacturer's installation instructions. CNS stated the family provided the bed rail and the bed. CNS-C stated there was no documentation the Consumer Product Safety Commission (CPSC) was reviewed for recalls. CNS-C stated for R1, they did not have the resident preferences documented and was unaware of the requirement. On September 9, 2025, at 12:39 p.m., RN-E stated there were no installation instructions for R2's file available and they did not know if the bed rail was installed correctly. RN-E stated they were not aware of the requirement to check the CPSC for recalls, and they were unaware resident preferences should be included in the assessments for R1, R2, R3, and R4. RN-E stated for R3 they did not complete the resident bed rail use/need assessment. RN-E stated that was an oversight for not completing that. On September 10, 2025, at 8:49 a.m., RN-E stated they did not look at the manufacturer's instructions for the Halo bed rail to ensure it was	02310		

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02310	Continued From page 22 installed correctly. RN-E stated there was no way to determine without referring to manufacturer's instruction if they were installed correctly. RN-E stated they did not have a lot of experience with bed rail assessments and was unsure of the difference between a hospital style bed rail and a consumer bed rail. RN-E was not aware of all the requirements for completing bed rail assessments. On September 10, 2025, at 8:52 a.m., CNS-C stated RNs should be using the referring to the correct manufacturer's instructions for the bed rails. CNS-C stated they were unsure why the correct manufacturer's instructions were not available. On September 10, 2025, at 12:10 p.m., CNS-C stated they were not able to locate the installation instructions for R1's bed rail. CNS-C stated they had previous knowledge of that particular bed rail but without the manufacturer's instruction, they could not confirm the bed rail was installed correctly. The licensee's 6.28 Side Rail policy dated August 1, 2021, indicated licensee would ensure the assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. The policy further indicated the RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. The policy also indicated the assessments must be completed regardless of who owns or is supplied the side rail.	02310		

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02310	Continued From page 23 The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Additionally, the FAQ indicated the nurse must abide by accepted health care standards, and the use of portable bed rails according to manufacturer's guidelines is one of those accepted standards. Documentation about a resident's bed rails includes, but is not limited to: - purpose and intention of the bed rail; - condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - the resident's bed rail use/need assessment; - risk vs. benefits discussion (individualized to each resident's risks); - the resident's preferences; - installation and use according to manufacturer's guidelines; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation and; - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. In addition, the MDH FAQ indicated licensees	02310		

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02310	Continued From page 24 should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information. The Food and Drug Administration's (FDA), A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated June 21, 2006 indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe". No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

CAREFREE COTTAGES OF MAPLEWOOD
1801 GERVAIS AVENUE
Maplewood, MN 55109
Ramsey County
Parcel:

Phone:

License Info

License: HFID 31221

Risk:
License:
Expires on:
CFPM: Gail M. Schwegel
CFPM #: 417128; Exp: 04/07/2028

Inspection Info

Report Number: F1021251130
Inspection Type: Full - Single
Date: 9/9/2025 Time: 10:37 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 4-500 Equipment Maintenance and Operation
4-501.12 *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.
COMMENT: THE CUTTING BOARD ON THE NORLAKE PREP COOLER IS PRETTY BADLY STAINED AND SCORED. IT SHOULD BE RESURFACED OR REPLACED. COMPLY WITH RULE ABOVE.
Comply By: 9/19/2025 Originally Issued On: 9/9/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: THE FRP WALL PANELS AROUND THE KITCHEN ARE BECOMING YELLOW, WITH SPLASHING OF DRIED FOOD DEBRIS, PARTICULARLY ON THE WALL NEXT TO THE HOT WELLS. THE CEILING VENTS ABOVE THE WAREWASHING AREA ALSO HAVE A VISIBLE ACCUMULATION OF DUST. CLEAN AND MAINTAIN CLEAN.
Comply By: 9/23/2025 Originally Issued On: 9/9/2025

Food & Beverage General Comment

All findings on this report were discussed with Executive Director (LALD), Phil Apel, Culinary Director/CFPM, Gail Schwegel and Health Regulation Division Nurse Evaluator, Keith Langley.

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 F1021251130 from 9/9/2025

Melissa Ramos

Phil Apel
Executive Director (LALD)

Melissa Ramos,
Public Health Sanitarian 3
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Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

CAREFREE COTTAGES OF MAPLEWOOD
Maplewood
County/Group: Ramsey County

Inspection Info

Report Number: F1021251130
Inspection Type: Full
Date: 9/9/2025
Time: 10:37 AM

Food Temperature: Product/Item/Unit: Mashed Potatoes **; Temperature Process:** Hot-Holding
Location: Hot Wells at 160 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Sliced Roast Beef **; Temperature Process:** Cold-Holding
Location: Norlake Prep Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Sliced Ham **; Temperature Process:** Cold-Holding
Location: Norlake Prep Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Grilled Chicken **; Temperature Process:** Cooking
Location: Flat Top at 168 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Gravy**; Temperature Process:** Hot-Holding
Location: Stove at 158 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Pork Loin **; Temperature Process:** Cooking
Location: Oven at 187 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cut Watermelon**; Temperature Process:** Cold-Holding
Location: True Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cut Tomato **; Temperature Process:** Cold-Holding
Location: True Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: Norlake Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

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Sanitizer Observations/Recordings

Establishment Info

CAREFREE COTTAGES OF MAPLEWOOD
Maplewood
County/Group: Ramsey County

Inspection Info

Report Number: F1021251130
Inspection Type: Full
Date: 9/9/2025
Time: 10:37 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 170 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** 3-Compartment Sink
Location: Dishwashing Area **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Front **Equal To** 200 PPM
Comment:
Violation Issued?: No