



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 28, 2026

Licensee

Maple Care Homes

8997 Montequ Terrace

Brooklyn Center, MN 55443

RE: Project Number(s) SL37437016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 17, 2026, 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.

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,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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: SL37437016-0 On September 14, 2026, through September 17, 2026, 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 five residents, all of whom received receiving services under the Assisted Living Facility license. An immediate correction order was identified on September 16, 2026, issued for SL37437016-0, tag identification 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	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 oMinnesota Department of Health is documenting the State Correction Orders using federal software. Tag ut 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.	

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
0 470	Continued From page 1	0 470			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the daily staff schedule was posted for residents, staff, and visitors to review as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
0 470	Continued From page 2 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 15, 2026, at 11:04 a.m., the surveyor inquired where the daily staffing schedule was posted. Unlicensed personnel (ULP)-B stated the daily staffing schedule was normally online. The surveyor again inquired if the licensee had a staffing schedule posted in the facility. ULP-B stated the daily staffing schedule was normally online and sometimes it was posted near the entry. The surveyor then observed an outdated staff schedule dated June 29, 2026, through July 5, 2026, located near the entry way. On September 16, 2026, at approximately 2:00 p.m., during an interview with clinical nurse supervisor (CNS)-C and housing manager (HM)-A, CNS-C stated human resources (HR) was responsible for posting the daily staff schedule. HM-A stated they created the daily staff schedule based on the registered nurse's (RN) staffing plan and HR was responsible for posting the daily staff schedule in the facility. HM-A stated the daily staff schedule was not posted due to a process failure, however, staff members had access to the daily staff schedule. The Minnesota Administrative Rules 4659.0180 subpart 4. Dated August 11, 2021, read, "A. The clinical nurse supervisor must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443			
(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
0 470	Continued From page 3 each direct-care staff member showing all work shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. B. The daily work schedule in item A must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure." The licensee's Staffing policy dated August 1, 2021, indicated a daily staffing schedule was prepared by the CNS. The schedule addressed ULP work schedules for each facility showing all work shifts with day and hours worked and the ULP's resident assignment or work location. In addition, the schedule was posted at the beginning of the shift in a central location and was accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
0 480	Continued From page 4 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, 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	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443			
(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
0 480	Continued From page 5 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 15, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443			
(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
0 900	Continued From page 6 provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract prior to providing housing or services for two of three residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
0 900	Continued From page 7 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: R1 R1 was admitted to the licensee on August 5, 2026, and began receiving assisted living services. R1's diagnoses included congestive heart failure, chronic obstructive pulmonary disease, and schizophrenia (mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking). R1's Assisted Living Contract was signed on August 18, 2026, 13 days after R1 admitted and began receiving services at the facility. On September 16, 2026, 11:48 a.m., housing manager (HM)-A stated R1 admitted to the facility in the evening hours, and R1 did complete some onboarding "items" including a review of the contract. HM-A stated new residents were given the option to complete admission documents by paper or set up an email where they could receive the information and store the information in a digital form. HM-A stated they created digital documents the day after R1 was admitted to the facility and sent them to R1 for them to review and sign on August 6, 2026. HM-A stated they had difficulty getting R1 to sign the contract	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
0 900	Continued From page 8 because R1 wanted a family member to review the documents prior to signing them. HM-A provided the surveyor with a document titled Certificate of Signature which indicated the contract was sent to R1 digitally on August 6, 2026, and R1 viewed the document on August 12, 2026. HM-A was unable to provide the surveyor additional documents that indicated the contract was reviewed with R1 on August 5, 2026. R3 R3 was admitted to the licensee on November 7, 2025, and began receiving assisted living services. R3 diagnoses included malnutrition, adult failure to thrive, unspecified mental disorder, and substance related disorder. R3's undated Assisted Living Contract included R3's signature, however, lacked the following requirements: - the document was not signed by a representative of the facility; and - the document lacked a date the document was signed on by the resident and completed by the representative of the facility. The surveyor was unable to determine if R3's contract was completed prior to providing services or housing for R3. On September 16, 2026, at 1:02 p.m., HM-A stated they completed contract signing with residents only when the licensed assisted living director (LALD)-D directed them too. HM-A did not know why R3's contract was not signed or dated by a representative of the facility. On September 17, 2026, at 8:25 a.m., LALD-D	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443			
(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
0 900	Continued From page 9 stated it was an oversight that R3's contract was not dated or signed by a representative of the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
01060	Continued From page 10 be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative for one of one resident (R1) who was hospitalized. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on August 5, 2026, and began receiving assisted living services.	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
01060	Continued From page 11 R1's diagnoses included congestive heart failure, chronic obstructive pulmonary disease, and schizophrenia (mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking). R1's Service Plan (Waiver) - Addendum to Contract signed August 24, 2026, indicated R1 received assistance with activities, ambulation, bathing, housekeeping, laundry, behavior management, meals, medication administration, vital sign monitoring, shopping, socialization, therapeutic exercises, transfers, and transportation. R1's progress note dated August 10, 2026, indicated R1 was sent to the hospital in the early morning after unlicensed personnel (ULP) found R1 sitting on the floor unable to rise to a standing position. R1's progress note dated August 12, 2026, indicated R1 returned from the hospital in the evening hours. R1's record lacked evidence that the licensee provided the resident or resident's representative with a written emergency relocation notice. On September 16, 2026, at approximately 2:00 p.m., during an interview with clinical nurse supervisor (CNS)-C and housing manager (HM)-A, CNS-C stated they did not know what an emergency relocation notice was. CNS-C stated they were hired on September 14, 2026. HM-A stated they had taken the responsibility for issuing the emergency relocation notices however, the nurse or licensed assisted living director (LALD) should have been the people to issue them.	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
01060	Continued From page 12 HM-A stated the licensee had an emergency relocation notice template that they completed and provided to the residents when they were sent to the hospital. HM-A stated the emergency relocation notice was then sent to OOLTC if a resident was hospitalized for more than four days. HM-A stated an emergency relocation notice was not provided to R1 due to a system process failure. HM-A stated they were not at the facility when R1 was sent to the hospital, so R1 did not receive the notice. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, indicated in the event of an emergency relocation, the facility would, as soon as possible, provide a written notice of emergency relocation to the following: - resident; - resident's legal representative; - residents designated representative - if the resident received home and community-based services, the resident's case manager. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 13 resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 14 prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a timely change of condition assessment for one of three residents (R1) following a return from hospitalization. In addition, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for one of three 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 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: COC ASSESSMENT R1 was admitted to the licensee on August 5, 2026, and began receiving assisted living services. R1's diagnoses included congestive heart failure, chronic obstructive pulmonary disease, and schizophrenia (mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking).	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 15 R1's Service Plan (Waiver) - Addendum to Contract signed August 24, 2026, indicated R1 received assistance with activities, ambulation, bathing, housekeeping, laundry, behavior management, meals, medication administration, vital sign monitoring, shopping, socialization, therapeutic exercises, transfers, and transportation. R1's progress note dated August 10, 2026, indicated R1 was sent to the hospital in the early morning after unlicensed personnel (ULP) found R1 sitting on the floor unable to rise to a standing position. R1's progress note dated August 12, 2026, indicated R1 returned from the hospital in the evening hours. R1's Assessment History included a Post Hospital Assessment completed on August 15, 2026. The assessment was completed three days after R1's return from the hospital. ONGOING ASSESSMENT R3 was admitted to the licensee on November 7, 2025, and began receiving assisted living services. R3 diagnoses included malnutrition, adult failure to thrive, unspecified mental disorder, and substance related disorder. R3's Service Plan - Modification signed June 4, 2026, indicated R3 received assistance with activities, appointments, bathing, dressing, grooming, housekeeping, laundry, behavior management, meals, medication administration, safety checks, shopping, socialization, and transportation.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 16 R3's Assessment History printed on September 16, 2026, included a 14-day assessment completed on November 25, 2026, and ongoing assessments completed on February 23, 2026, and May 24, 2026, which indicated R3 required an ongoing assessment on or before August 22, 2026. R3's record lacked additional assessments completed after May 24, 2026. On September 16, 2026, at approximately 2:00 p.m., during an interview with clinical nurse supervisor (CNS)-C and housing manager (HM)-A, CNS-C stated they were not working for the company when R1 returned from the hospital. CNS-C stated they started employment with the licensee on September 14, 2026. HM-A stated they did not know why a change of condition assessment was not completed for R1 upon their return from the hospital however, as they had made registered nurse (RN)-F aware of R1's return. HM-A also stated they did not know why R3's assessment had not yet been completed and RN-F was responsible for completing both assessments. HM-A then attempted to get ahold of RN-F via phone to inquire about the assessments listed above. On September 16, 2026, at 2:50 p.m., RN-F stated R1's assessment was not completed because they were not available to come to the facility on the date R1 returned. RN-F stated they assisted the licensee based on their own availability. RN-F stated once they were able, they completed the assessment with R1. RN-F stated they did not know why R3's assessment was late. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 17 resident assessments must be conducted as needed based on changes in the needs of the resident and may be completed by other licensed nurses acting within their scope of licenses. In addition, ongoing resident reassessment must be conducted by a registered nurse (RN) and cannot exceed 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443			
(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
01640	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to finalize a current written service plan no later than 14 calendar days after the date that services were first provided for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on August 5, 2026, and began receiving assisted living services. R1's diagnoses included congestive heart failure, chronic obstructive pulmonary disease, and schizophrenia (mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking). On September 15, 2026, at 9:46 a.m., the surveyor observed unlicensed personnel (ULP)-E administer oral medications to R1. R1's Service Plan (Waiver) - Addendum to Contract signed by R1 and the licensee on August 24, 2026, indicated R1 received assistance with activities, ambulation, bathing, housekeeping, laundry, behavior management,	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
01640	Continued From page 19 meals, medication administration, vital sign monitoring, shopping, socialization, therapeutic exercises, transfers, and transportation. R1's record lacked documentation of efforts to get R1's service plan finalized within 14 days. On September 16, 2026, at 7:10 a.m., via email, the surveyor requested documentation of a service plan completed prior to August 24, 2026 (the initial service plan). On September 16, 2026, at 9:36 a.m., housing manager (HM)-A stated the service plan listed above was R1's first service plan. HM-A stated the licensee had difficulty obtaining R1's signature for the service plan because they wanted their sister to review the document and R1 kept going to the hospital. HM-A stated they printed and provided the service plan to R1 on the effective date listed on the document of August 6, 2026. The surveyor requested documentation of attempts the licensee made to have R1 sign the service plan. On September 16, 2026, at 11:20 a.m., R1 asked the surveyor if they were the person they were supposed to speak with regarding not signing documents right away, which indicated the licensee spoke to R1 about the surveyor's inquiry prior to the surveyor's interview with R1. R1 stated they had poor vision and normally did not sign documents until a family member reviewed them. On September 16, 2026, at approximately 11:50 a.m., HM-A provided the surveyor with R1's contract (a document previously requested via email by the surveyor at the same time R1's service plan was requested) along with a	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
01640	Continued From page 20 document titled Certificate of Signature from PandaDoc (an electronic application to create, send, track, and e-sign proposals, contacts, quotes, and forms) attached to the document. The document indicated a sent date of August 6, 2026, and a viewed date of August 12, 2026. The surveyor asked if HM-A located documentation of their attempt to provide the service plan for signature to R1. HM-A then stated the contract and the service plan were sent together through PandaDoc. The surveyor requested to see either proof of the attachments sent on August 6, 2026, with PandaDoc or a supportive email or progress note. HM-A stated they would look. On September 16, 2026, at approximately 2:00 p.m., the surveyor again requested documentation of attempts to have R1 sign the service plan prior to day 14. HM-A stated the electronic document did not show the attachments sent, and they were unable to provide the surveyor with any supportive documentation that the service plan was reviewed or sent to R1 or R1's family member prior to the date the service plan was signed. The surveyor observed that the contract was electronically signed by R1's sister in a digital format on August 18, 2026, and the service plan was physically signed by R1 on August 24, 2026. Although HM-A stated they attempted to have R1 finalize their service plan timely, the service plan was also not signed by the licensee on the effective date. In addition, the licensee was unable to provide documentation of attempts the licensee made to review or sign R1's service plan. The licensee's 6.08 Service Plan policy dated November 15, 2024, indicated within 14 days	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
01640	Continued From page 21 after the date that services were first provided to a resident, the licensee would finalize a written service plan. In addition, other optional documents such as "care plans", "assignment sheets", or other internal documents may be used to assist staff in understanding their daily assignments and tasks, but such documents were not required and do not replace the required service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified 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	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
01730	Continued From page 22 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 medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a current individualized medication management plan to include all required content for two of three residents (R1, 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 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	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
01730	Continued From page 23 found to be pervasive). The findings include: R1 R1 was admitted to the licensee on August 5, 2026, and began receiving assisted living services. R1's diagnoses included congestive heart failure, chronic obstructive pulmonary disease, and schizophrenia (mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking). R1's Service Plan (Waiver) - Addendum to Contract signed August 24, 2026, indicated R1 received assistance with activities, ambulation, bathing, housekeeping, laundry, behavior management, meals, medication administration, vital sign monitoring, shopping, socialization, therapeutic exercises, transfers, and transportation. On September 15, 2026, at 9:46 a.m., the surveyor observed unlicensed personnel (ULP)-E administer oral medications to R1. On September 15, 2026, at 10:32 a.m., the surveyor observed R1's medications stored in the licensee's medication cabinets. R1's prescriber orders dated August 14, 2026, included the following: - ondansetron 4 milligrams (mg) dissolve 1-2 tablets (4 mg to 8 mg) in mouth every eight hours as needed (PRN) for nausea; and - acetaminophen 500 mg take 1-2 tablets by mouth every four hours PRN. Max	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
01730	Continued From page 24 acetaminophen 4000 mg in 24 hours. R1's medication administration record (MAR) dated August 2026 included the following: - ondansetron 4 mg dissolve one to two tablets (4mg to 8 mg) in mouth every eight hours PRN for nausea; and - acetaminophen 500 mg take one to two tablets by mouth every four to six hours PRN. Do not exceed eight tablets in 24 hours. The MAR did not provide specific instructions for when staff should administer one tablet verses two tablets for acetaminophen and ondansetron. R1's Assessment dated August 15, 2026, included part of R1's medication management plan and indicated the following: - the facility nurse would set up medications and the ULP would administer them at the scheduled times to R1; - the facility nurse or ULP would manage and reorder medications as needed (PRN); and - R1 preferred to take their medication with apple sauce. R1's individualized medication management plan comprised of multiple documents lacked the following required information: - type of medication storage system, based on R1's needs; - specific written instructions for medication administration when delegated to a ULP; - medication management tasks that may be delegated to ULPs; and - procedures for staff to notify an RN when problems arise. R4 R4 was admitted to the licensee on March 25,	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
01730	Continued From page 25 2024, and began receiving assisted living services. R4 diagnoses included diabetes, and kidney failure with dialysis treatment. R4's Service Plan - Modification signed June 2, 2026, indicated R4 received assistance with activities, appointment reminders, bathing, dressing, drinking, financial, grooming, housekeeping, toileting, laundry behavior management, meals, medication administration, nail care, positioning, vital sign monitoring, safety check, shopping, skin care, socialization, transfer assistance, transportation, and wheelchair use. On September 15, 2021, at 9:21 a.m., the surveyor observed ULP-B administer two drops of Genteal tears into both of R4's eyes. R4's prescriber orders dated July 7, 2026, included Genteal Tears 0.1-0.2-0.3 percent (%) solution instill one to two drops in both eyes twice daily. R4's MAR dated September 2026 included the following medication orders: - Genteal Tears Mild eye drop take one to two drops into both eyes twice per day. The MAR did not provide specific instructions for when staff should administer one eye drop verses two eye drops. R4's Assessment dated September 10, 2026, included part R4's medication management plan and indicated the following: - medications would be set up for ULP to administer to R4 at scheduled times; - R4 preferred to take their medication all at once with cold water;	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
01730	Continued From page 26 - the nurse would reorder medication and supplies as needed; - the facility nurse would set up medication weekly; - all meds were stored in a locked cabinet; - ULP were delegated eye drops and oral medications; and - ULP where to call or use text message to contact the nurse if question or concern arouse with medications. R4's medication management plan comprised of multiple documents lacked the following required information: -specific written instructions for resident medication administration when delegated to a ULP. On September 16, 2026, at approximately 2:00 p.m., during an interview with clinical nurse supervisor (CNS)-C and housing manger (HM)-A, CNS-C verified the content listed above was not address (box not checked) on the Residex (a documenting software) for R1. CNS-C stated the licensee hired them on September 14, 2026. CNS-C stated they were not employed by the licensee at the time the assessments were completed, so they did not know why the assessments were incomplete. HM-A stated the on-call nurse completed R1's assessment and must have missed the questions. The surveyor inquired if R4 should receive one or two Genteal tears eye drops in each eye. CNS-C stated, "the order says one to two and that puts it into the staff hands." CNS-C stated the instruction for the eye drop needed to be more specific and they would need to reach out to the prescriber to receive a new order. CNS-C stated they were not employed by the licensee when the order was placed into the chart so they did not know why the orders	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443			
(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
01730	Continued From page 27 were not clarified. The surveyor discussed the other medications listed above that lacked parameters with CNS-C. CNS-C stated the medications should have clear instructions of how much medication to provide. The licensee's Service Plan for Medication Management policy dated August 1, 2021, indicated the written medication management plan would include the following provisions: - a statement describing the medication management services to be provided; - a description of storage of medications based on the resident assessment; - documentation of procedures; - procedures for medication reconciliation; - identification of person (s) responsible for monitoring medication supplies and ensuring refills were ordered timely; - description of medication management tasks to be delegated to unlicensed personnel; - plans for staff notifying the licensed health professional when/if a problem arose with medication management services; and - any resident-specific requirements related to documenting medication administration, verification that all medications were administered as prescribed and monitoring of medications use to prevent possible complications and adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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
01890	Continued From page 28 immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discard expired medication for two of four residents (R1, 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 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 15, 2026, at 10:32 a.m., the surveyor observed the licensee's medication cabinets and observed the following expired medications: - two bottles of prednisolone acetate ophthalmic eye drop opened on April 16, 2026, for R3; - two bottles of ofloxacin ophthalmic solution opened on April 16, 2026, for R3; - one card of loratadine 10 milligrams (mg) for R1. On September 16, 2026, at 2:00 p.m., during an interview with clinical nurse supervisor (CNS)-C and housing manger (HM)-A, CNS-C stated they	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443			
(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
01890	Continued From page 29 were hired on September 14, 2026, and they planned to review the medication cabinets weekly. CNS-C stated they did not know why the medication cabinet contained expired medications. HM-A stated the eye drops listed above were placed on hold due to R3 not having eye surgery and the medications needed to be disposed of. HM-A stated nurses would make progress notes in the system when they reviewed the medication cabinets, and they discussed the medication cabinets at the licensee's weekly meetings. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, indicated discontinued medication may be kept until the expirations dates if there was a possibility of resuming the medication. If not resumed before the expiration date, it would be disposed of according to this policy. In addition, medications that were expired may be provided for disposal. The manufacturer's instructions for ofloxacin ophthalmic solution dated April 2020 indicated once a bottle of ofloxacin ophthalmic solution should be discarded four weeks after first opened. The manufacturer's instructions for prednisolone acetate ophthalmic eye drops dated January 20, 2023, indicated prednisolone acetate ophthalmic solution should be discarded 28 days after first opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 30	02310			
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 one of one resident (R1) who utilized consumer bed rails. 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: R1 was admitted to the licensee on August 5, 2026, and began receiving assisted living services. R1's diagnoses included congestive heart failure, chronic obstructive pulmonary disease, and schizophrenia (mental disorder that affects how a person thinks, feels, and behaves, often leading to hallucinations, delusions, and disorganized thinking).	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 31 R1's Service Plan (Waiver) - Addendum to Contract signed August 24, 2026, indicated R1 received assistance with activities, ambulation, bathing, housekeeping, laundry, behavior management, meals, medication administration, vital sign monitoring, shopping, socialization, therapeutic exercises, transfers, and transportation. On September 16, 2026, at 9:27 a.m., the surveyor observed an unsecured KingPavonini bed assist rail product model BM03-1 on R1's upper left side of the bed. The surveyor observed that the safety strap was not secured around the bed frame. R1's Bed Safety Assessment dated August 15, 2026, included the following: - R1 had an electric bed; - R1 used a "top half of bed rails" to assist with transfers and positioning while in bed; - R1 had difficulty with transfers due to weakness and osteoarthritis pain, and the bed rails would provide support to assist with bed repositioning, transfers, and mitigate falls; - bed rails were appropriate based on assessed need and resident preference; - the bed rail did not function as a restraint; - possible injury could occur due to poor vision and muscle weakness; - there was no history of injury related to bed rails; - R1 was on Haldol, lamotrigine, mirtazapine, and olanzapine which could affect mental status and increase risk of injury with the use of bed rails; - risk and benefits of bed rails had been provided to R1; and - the bed rail met FDA requirements. R1's record lacked the following information related to bed rails:	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 32 - the type of bed rail R1 used; - if the United States Consumer Product Safety Commission (CSPC) was checked for recalls on R1's bed rail; - manufacturer's instructions for R1's bed rail; and - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation. On September 16, 2026, 9:41 a.m., housing manager (HM)-A stated they did not have the manufacturer's instructions for R1's bed rail. HM-A stated they watched a video for how to install the bed rail. HM-A stated the Residex (a documenting software program) assessments were standardized and did not include an aread to address the type of bed rail, if CSPC was checked for recalls, and if the bed rail was inspected after installation. CNS-C stated bed rails have to be under certain measurements in order for the residents not to get entrapped. CNS-C stated they also have the residents and/or guardian sign a risk and benefit document if bed rails were used. CNS-C stated they started employment with the licensee two days ago. The surveyor explained consumer bed rails and CNS-C stated they were assessing consumer bed rails incorrectly at their previous employer. On September 16, 2026, at 10:10 a.m., the surveyor observed HM-A attempting to install the consumer bed rail. HM-A stated R1 received a new bed after admission, and they believed R1's nephew installed the bed rail. R1 stated that an employee at the facility installed it and not their nephew. The Minnesota Department of Health (MDH) website, Assisted Living Resources &	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 33 Frequently-Asked Questions (FAQs) dated April 17, 2026, "Unlike hospital beds, there is no current published guidance related to portable bed rails used on non-hospital style beds ("consumer beds"), so licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees 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 FAQ also 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." Also, it included, "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 - Any necessary information related to interventions to mitigate safety risk or negotiated	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/17/2026
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 34 risk agreements". The licensee's Side Rail Use policy dated August 1, 2021, indicated before implementing bed rails for a resident the registered nurse (RN) would conduct a bed rail assessment, provide education related to the bed rails to the resident or resident's representative, and document the purpose of the bed rails and the education provided. In addition, the RN was responsible to ensure the bed rails in use were of a safe design and properly maintained. Bed rails would be used consistent with the manufacturer's recommendations. If the manufacturer's recommendation were not available, the RN would use appropriate judgment related to the implementation of bed rails. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			

Food & Beverage Inspection Report

Page: 1

Establishment Info

MAPLE CARE HOMES
8997 MONTEQUE TERRACE
Brooklyn Park, MN 55443
Hennepin County
Parcel:

Phone:

License Info

License: HFID 37437

Risk:
License:
Expires on:
CFPM: CAMEO SCHAVON
ANDERSON
CFPM #: 57188; Exp: 3/18/2028

Inspection Info

Report Number: F1068261109
Inspection Type: Full - Single
Date: 9/15/2026 Time: 9:41:31 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

! New Order: 2-200 Employee Health

2-201.11C Priority Level: Priority 1 CFP#: 3

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

COMMENT: NO EMPLOYEE ILLNESS LOG PRESENT. EMPLOYEE ILLNESS LOG SENT WITH INSPECTION REPORT.

Comply By: 9/15/2026 Originally Issued On: 9/15/2026

! New Order: 3-500D Microbial Control: disposition of food

3-501.18A Priority Level: Priority 1 CFP#: 23

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

COMMENT: COMMERCIALY PACKAGED PICO DE GALLO IN REFRIGERATOR WITH DATE MARK INDICATING THE CONTAINER HAD BEEN OPENED MORE THAN 7 DAYS PRIOR. CONTAINER OF PICO DE GALLO DISCARDED DURING INSPECTION. CORRECTED.

Comply By: 9/15/2026 Originally Issued On: 9/15/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111C Priority Level: Priority 2 CFP#: 38

MN Rule 4626.1565C Use approved trapping devices or other means of pest control when pests are found.

COMMENT: FRUIT FLIES IN KITCHEN AROUND SINK DRAIN AND GARBAGE CAN.

Comply By: 9/15/2026 Originally Issued On: 9/15/2026

Food & Beverage General Comment

THE INSPECTION WAS COMPLETED AND DISCUSSED WITH THE PERSON IN CHARGE AND HEALTH REGULATION DIVISION NURSING EVALUATOR, ASHLEY CREWS (MDH).

THE ESTABLISHMENT HAS A RESIDENTIAL GRADE KITCHEN, INCLUDING THE REFRIGERATOR AND DISH MACHINE. THE KITCHEN FINISHES ARE AS FOLLOWS:

FLOORS: WOOD PLANK
WALLS: SMOOTH, PAINTED DRYWALL & TILE
CEILINGS: SMOOTH, PAINTED
FURNISHINGS: WOODEN CABINETS

THE ESTABLISHMENT HAS A SCHEDULED MEAL MENU FOR RESIDENTS. THE PERSON IN CHARGE STATED THAT ALL FOOD PREPARED FOR RESIDENTS IS KEPT NO LONGER THAN A DAY, USING SAME DAY SERVICE.

THE FOLLOWING TOPICS WERE DISCUSSED DURING THE INSPECTION:

- HANDWASHING & DISPOSABLE GLOVE USE
- SANITIZATION CYCLE ON THE RESIDENTIAL DISH MACHINE
- SERVING A HIGHLY SUSCEPTIBLE POPULATION
- SAME DAY SERVICE
- BODILY FLUID CLEAN-UP PROCEDURES
- EMPLOYEE ILLNESS POLICY AND REPORTING PROCEDURES

THE PERSON IN CHARGE PROVIDED PICTURES OF THE FOLLOWING POST INSPECTION:

1. A HIGH TEMPERATURE REGISTERING STICKER SHOWING THAT THE DISH MACHINE'S SANITIZING RINSE CYCLE REACHED A MINIMUM TEMPERATURE OF 160 DEGREES F.

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 inspection report number F1068261109 from 9/15/2026

Gabriel Stark

Cameo Schavon Anderson
Food Safety Manager

Gabe Stark,
Public Health Sanitarian 2
gabe.stark@state.mn.us

Temperature Observations/Recordings

Page: 1

Establishment Info	Inspection Info
MAPLE CARE HOMES	Report Number: F1068261109
Brooklyn Park	Inspection Type: Full
County/Group: Hennepin County	Date: 9/15/2026
	Time: 9:41:31 AM

Equipment Temperature: **Product/Item/Unit:** AMBIENT ; **Temperature Process:** Ambient Air

Location: Refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT; **Temperature Process:** Ambient Air

Location: FREEZER at 12 Degrees F.

Comment:

Violation Issued?: No



, MN

Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
MAPLE CARE HOMES Brooklyn Park County/Group: Hennepin County	Report Number: F1068261109 Inspection Type: Full Date: 9/15/2026 Time: 9:41:31 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 180 Degrees F.

Comment: RESIDENTIAL DISH MACHINE

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Kitchen **Equal To** 400 PPM

Comment:

Violation Issued?: No