Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 12, 2025

Licensee
Caretta Senior Living Maplewood LLC
1910 County Road C East
Maplewood, MN 55109

RE: Project Number(s) SL40883015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on September 25, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

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

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

DOCUMENTATION OF ACTION TO COMPLY
Per 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 residents/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

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

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 MDH 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 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
	40883	A. BUILDING: _____ B. WING _____	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARETTA SENIOR LIVING MAPLEWOOD LLC	1910 COUNTY ROAD C EAST MAPLEWOOD, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40883015-0 On September 22, 2025, through September 25, 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 14 residents; all receiving services under the Provisional 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.	
0 180 SS=F	144G.16 Subd. 2 Initial survey	0 180		

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0 180	Continued From page 1 (a) During the provisional license period, the commissioner shall survey the provisional licensee after the commissioner is notified or has evidence that the provisional licensee is providing assisted living services to at least one resident. (b) Within two days of beginning to provide assisted living services, the provisional licensee must provide notice to the commissioner that it is providing assisted living services by sending an e-mail to the e-mail address provided by the commissioner. (c) If the provisional licensee does not provide services during the provisional license period, the provisional license shall expire at the end of the period and the applicant must reapply. (d) If the provisional licensee notifies the commissioner that the licensee is providing assisted living services within 45 calendar days prior to expiration of the provisional license, the commissioner may extend the provisional license for up to 60 calendar days in order to allow the commissioner to complete the on-site survey required under this section and follow-up survey visits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the Minnesota Department of Health (MDH) within two days of beginning to provide assisted living services under the provisional assisted living license. 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	0 180		

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0 180	Continued From page 2 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee was issued their provisional assisted living facility license on September 27, 2024. R2 was admitted to the licensee on October 10, 2024, to receive assisted living services. R2's diagnoses included chronic kidney failure, type 2 diabetes, hypertension, and major depressive disorder. R2's Service Agreement last updated on September 22, 2025, indicated R2 received services including assistance with medication management, blood glucose monitoring, transfers, bathing, dressing, and housekeeping. The service agreement indicated R2 received supportive services of evacuation assistance effective October 10, 2024, and bedmaking effective October 24, 2024. The service agreement indicated R2 began receiving assisted living services of nail care and topical medication administration on November 15, 2024. R2's [licensee name] Lease Agreement, effective date October 9, 2024, indicated R2 and former executive director (ED)-M both signed the agreement on October 16, 2024. The licensee's Notice of Providing Assisted Living Services document indicated the licensee began providing assisted living services to two residents	0 180		

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0 180	Continued From page 3 on October 1, 2024. The document was signed by ED-M on December 2, 2024. Minnesota Department of Health (MDH) documentation indicated the Department received the licensee's Notice of Providing Assisted Living Services document on December 2, 2024. The notification was provided more than two days after R2 began receiving assisted living services. On September 22, 2025, at 3:30 p.m., R2 explained he was one of the first residents to be admitted to licensee in early October 2024, and that he had been there almost one year. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 180		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted	0 430		

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0 430	Continued From page 4 living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the uniform checklist disclosure of services (UDALSA) accurately reflected services provided by the licensee. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's provisional assisted living license was issued on September 27, 2024. On September 22, 2025, at 11:10 a.m., during a facility tour with executive director (ED)-C, the surveyor observed a "U" shaped facility with two floors. The center of the first floor included common areas such as dining/club room, front desk with lobby, activity room, and library. To the left of the front desk was the licensee's secured memory care unit including 26 memory care apartments. To the right of the desk were assisted living apartments. The second level also had assisted living apartments. ED-C stated the facility had two health facility identification (HFID)	0 430		

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0 430	Continued From page 5 numbers. The secured memory care unit was licensed as assisted living facility with dementia care (HFID 40223), and the rest of the facility was licensed as assisted living facility (HFID 40883). R3's record included a signed UDALSA updated on October 29, 2024. The UDALSA included two HFIDs, 40223 and 40883, and indicated the licensee was licensed as assisted living facility with dementia care (the licensee's HFID was for an assisted living facility, not assisted living facility with dementia care). The UDALSA indicated under "Dementia Care Services Available" a secured unit or building for wandering or exit-seeking behavior and secured outdoor grounds on facility premises were available within the memory care unit. R3's record lacked evidence the resident received a copy of the licensee's UDALSA to include: - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. On September 22, 2025, at 2:00 p.m., director of operations/licensed assisted living director (LALD)-L stated before a prospective resident signed the lease, the resident/resident's representative would sign the reservation agreement which included the down payment to reserve the room, sign the release of information form, and sign the UDALSA. The UDALSA provided was used for both HFID 40223 and HFID 40883.	0 430		

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0 430	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content	0 650		

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0 650	Continued From page 7 for two of two employees (unlicensed personnel (ULP)-B, ULP-E). 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: ULP-B ULP-B was hired on January 20, 2025, to provide direct assisted living services for the licensee's residents. On September 23, 2025, between 8:36 a.m., and 9:27 a.m., the surveyor observed ULP-B assist R2 with toileting, blood glucose monitoring, and medication administration. The surveyor observed an EZ stand lift (sit to stand lift allowing a resident to bear partial weight) within R2's room. ULP-B stated the lift was used for showers. ULP-E ULP-E was hired on November 18, 2024, to provide direct assisted living services to the licensee's residents. On September 23, 2025, at 11:20 a.m., the surveyor observed ULP-E assisting R3 with medication administration. The surveyor observed an Invacare Reliant electric Hoyer (full body lift for transfers) in R3's room.	0 650		

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0 650	Continued From page 8 DOCUMENTATION OF TRAINING/COMPETENCIES ULP-B's employee record included training on care of hearing assistance devices, but lacked documented competency on hearing aid use. ULP-B and ULP-E's employee records lacked documentation of competency in delegated skills including: -medication administration for all routes including topical (creams, ointment, powders), ear drops, nasal sprays, inhalers, vaginal medication/suppository, and rectal suppository; -preparing medication for unplanned time away; and -mechanical lifts (sit to stand and Hoyer). On September 23, 2025, at 2:00 p.m., regional director of clinical operations (RDCO)-D explained the licensee's medication training for new hires included training on medication set up for a leave of absence (LOA), but they did not have documentation of training or documentation of demonstrated competencies available for anyone who was hired before the licensee utilized the new forms. On September 23, 2025, at 2:25 p.m., ULP-F explained the medication set up procedure for an LOA, but was unable to explain how they would print a medication list for the resident to use during the LOA. During phone interview on September 24, 2025, at 1:16 p.m., director of training (DOT)-J explained she was the corporate trainer for all new hires. The training forms used for ULP-B and ULP-E were old and not currently in use.	0 650		

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0 650	Continued From page 9 DOT-J explained return demonstrations were meant to be completed by the facility RN. DOT-J further explained that due to the variability in mechanical lifts, they provided general training, but relied on the facility RN's to complete the training and competencies using their specific lifts. DOT-J further stated they did train and test competency on hearing aide care and medication set up for an LOA, but did not realize it was missing on their newest form, and would add it. On September 24, 2025, at 2:58 p.m., clinical nurse supervisor (CNS)-A stated he would watch staff complete medication administration before working on their own but did not document his observations in the employee record. The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, indicated the RN would verify the ULP was trained, competent and was instructed in the proper methods to perform the task with respect to the specific resident. The licensee's Training Documentation policy dated August 1, 2021, indicated a record of staff training and competency would be maintained in the employee file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.	0 900		

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0 900	Continued From page 10 (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 provide to the Office of Ombudsman for Long-Term Care (OOLTC) a complete unsigned copy of the assisted living contract. This had the potential to affect all current residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on	0 900		

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0 900	Continued From page 11 the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's provisional license was issued on September 27, 2024. During the entrance conference on September 22, 2025, at 10:15 a.m., executive director (ED)-C stated the licensee was familiar with current minimum assisted living requirements. R2 was admitted to the licensee on October 10, 2024, to receive services. R2's diagnoses included chronic kidney failure, type 2 diabetes, hypertension, and major depressive disorder. R3 was admitted to the licensee September 18, 2025, to receive assisted living services. R3's diagnoses included subdural hemorrhage (brain bleed), asthma, anxiety, and depression. R2 and R3's record included signed copies of an assisted living contract dated October 9, 2024, and September 17, 2025, respectively. On September 18, 2025, at 4:23 p.m., the regional ombudsman from the OOLTC replied to the surveyor's email, indicating they never received the licensee's unsigned copy of the assisted living contract.	0 900		

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	40883	A. BUILDING: _____ B. WING _____	09/25/2025

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0 900	Continued From page 12 On September 22, 2025, at 3:10 p.m., the surveyor asked director of operations/licensed assisted living director (LALD)-L if a blank assisted living contract was sent to OOLTC, he stated "I am sure it was sent when we first opened." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (6) billing and payment procedures and requirements; and	0 920		

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0 920	Continued From page 13 (7) disclosure of the facility's ability to provide specialized diets. 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 with the required content for two of two residents (R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's provisional assisted living license was issued on September 27, 2024, and set to expire on September 26, 2025. During facility tour with executive director (ED)-C on September 22, 2025, at 11:10 a.m., the surveyor observed a "U" shaped facility with two floors. The center of the first floor included common areas such as dining/club room, front desk with lobby, activity room, and library. To the left of the front desk is the licensee's secured memory care unit including 26 memory care apartments. To the right of the desk are assisted living apartments. The second level also had assisted living apartments. ED-C stated the facility had two health facility identification (HFID) numbers where the secured memory care unit was licensed as assisted living facility with dementia care (HFID 40223), and the rest of the	0 920		

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0 920	Continued From page 14 facility was licensed as assisted living facility (HFID 40883). R2 and R3 were admitted for services on October 10, 2024, and September 18, 2025, respectively. R2 and R3's record included signed copies of an assisted living contract dated October 9, 2024, and September 17, 2025, respectively. Both contracts indicated the licensee was licensed by the Minnesota Department of Health (MDH) as an assisted living facility with dementia care. The contact included both HFID: 40223 and 40883. The licensee lacked a written contract with the following required content: - a disclosure that it did not hold an assisted living facility with dementia care license. On September 22, 2025, at 2:28 p.m., director of operations/licensed assisted living director (LALD)-L stated the above assisted living contract was the only contract available and it was used for both HFIDs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor	0 970		

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0 970	Continued From page 15 include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 22, 2025, at 10:15 a.m., executive director (ED)-C stated the licensee was familiar with current minimum assisted living requirements. R2 was admitted to the licensee on October 10, 2024, to receive services. R2's diagnoses included chronic kidney failure, type 2 diabetes, hypertension, and major depressive disorder. R3 was admitted to the licensee September 18, 2025, to receive assisted living services. R3's diagnoses included subdural hemorrhage	0 970		

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0 970	Continued From page 16 (brain bleed), asthma, anxiety, and depression. R2 and R3's record included signed copies of an assisted living contract dated October 9, 2024, and September 17, 2025, respectively. The contract included the following statement on Page 10 under 15. Resident Handbook: "By signing this Agreement, Resident agrees to abide by Provider's policies, rules and regulations, which are described in the Resident Handbook and which are incorporated by reference into this Agreement." The licensee's undated resident handbook, included the following: -Page 12, under Liability: "[licensee name] are not responsible for any loss, injury or damages suffered as result of the acts of any other resident of [licensee name]." On September 22, 2025, at 2:00 p.m., director of operations/licensed assisted living director (LALD)-L stated the resident handbook, lease, and service agreement were given to every resident upon admission. -At 3:00 p.m., LALD-D stated the licensee's lease did not contain a waiver of liability, but the resident handbook did include a waiver of liability. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 17 (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 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.	01730		

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01730	Continued From page 18 (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 an accurate individualized medication management record for one of one resident (R2) receiving medication management services. 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: R2 was admitted for services on October 10, 2024, and had diagnoses including chronic kidney disease, type 2 diabetes, weakness, and high blood pressure. R2's Service Agreement signed September 22, 2025, indicated R2 received services including assistance with medication administration and blood glucose monitoring. R2's medication administration record (MAR) for September 2025, indicated R2 was scheduled and administered the following medications:	01730		

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01730	Continued From page 19 -Novolin N FlexPen (insulin), inject 10 units subcutaneously (SQ) every morning at 8:00 a.m. (10 units ended after September 19, 2025). -Novolin N FlexPen, inject 5 units SQ every morning at 8:00 a.m. (started September 20, 2025). The MAR indicated the following additional information: Do not refrigerate after opening for use. Store at room temperature. Okay to hold Novolin insulin if blood glucose (BG) is less than 80. Notify provider if BG is greater than 350. Screw pen needle onto insulin pen. dial the insulin pen to 2 units. Push the plunger and discard the 2 units of insulin into the trash or sink. Once completed, dial the pen to the correct units on the MAR. On September 23, 2025, at 8:36 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R2 with personal cares and medication administration. The surveyor observed a bottle of partially used Robitussin cough syrup and two tubes (one nearly empty and one full) of ammonium lactate 12% cream (used for dry skin) sitting on R2's bathroom countertop. The surveyor observed ULP-B apply ammonium lactate 12% to R2's reddened buttocks. -At 9:15 a.m., clinical nurse supervisor (CNS)-A directed ULP-B that insulin and eye drops also needed to be administered. ULP-B accessed R2's electronic medication administration record (EMAR) and set up the Novolin FlexPen correctly but failed to properly resuspend the insulin prior to administering. The surveyor observed the insulin appeared to not have been mixed, being half clear liquid and half opaque/white liquid. R2's Physician Order Sheet dated September 19, 2025, ordered Novolin FlexPen injection, inject 5	01730		

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01730	Continued From page 20 units SQ every morning. The physician order sheet did not include ammonium lactate or Robitussin as a current order. R2's record lacked specific written instructions for mixing R2's Novolin insulin. R2's Master Assessment (nursing assessment) dated September 17, 2025, indicated R2 did not plan to self-administer any medication and staff would be administering oral, topical, drops, and injections. The assessment also indicated medications would be kept in a locked medication cart and locked medication refrigerator. The assessment did not indicate any medications would be stored within R2's room. Novolin N manufacturer instruction sheet revised November 2022, indicated, "To resuspend FlexPen, gently move the pen up and down 20 times so the glass ball moves from one end of the cartridge to the other until the suspension appears uniformly white and cloudy. Inject immediately." On September 23, 2025, at 10:00 a.m., ULP-B stated she was trained by the corporate nurse to roll the insulin when it was removed from the refrigerator to "warm it up." On September 23, 2025, at 2:35 p.m., CNS-A stated they did not know if mixing Novolin prior to administration was required. CNS-A further stated they were not aware R2 had ammonium lactate on their bathroom counter-top but stated R2 was competent to self-administer over-the-counter medications such as Robitussin. CNS-A also stated the licensee recently began administering medications to R2 because he told	01730		

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01730	Continued From page 21 them it was "getting to be too much for him." On September 24, 2025, at 1:16 p.m., during a telephone interview, director of training (DOT)-J stated staff were trained that insulin needed to be mixed by rolling back and forth in the palms of their hands 10 times. The licensee's Individualized Medication, Treatment & Therapy Management Plans policy revised May 24, 2022, indicated the registered nurse (RN) would develop a medication management plan for each resident receiving medication management services. The medication management plan would include: -documentation of specific resident instructions relating to the administration of medications -description of medication storage based upon the resident's needs, preferences, risk of diversion, and in keeping with the manufacturer's instructions. The licensee's Storage of Medications policy revised December 29, 2022, indicated the RN would recommend where medications should be stored in the resident's home within the resident's individualized medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must	01760		

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01760	Continued From page 22 include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to administer medications according to provider orders for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R2 had diagnoses including chronic kidney disease, type 2 diabetes, weakness, and high blood pressure. R2's Service Agreement signed September 22, 2025, indicated R2 received services including assistance with medication administration and blood glucose monitoring.	01760		

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01760	Continued From page 23 On September 23, 2025, at 8:36 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R2 with personal cares and medication administration. ULP-B assisted R2 onto the toilet. The surveyor observed two tubes (one nearly empty and one full) of ammonium lactate 12% cream (used for dry skin) sitting on R2's bathroom countertop. The surveyor observed ULP-B apply ammonium lactate 12% to R2's reddened buttocks. -At 9:15 a.m., clinical nurse supervisor (CNS)-A provided ULP-B a medication cup with unknown oral medications for R2. CNS-A directed ULP-B that insulin and eye drops also needed to be administered. ULP-B administered the oral medication that were set up by CNS-A along with eye drops, topical gel for pain, and insulin. ULP-B set up the insulin (Novolin FlexPen) correctly but failed to properly resuspend the insulin prior to administering as per the manufacturer directions. The surveyor observed the insulin appeared to not have been mixed, being half clear liquid and half opaque/white liquid. -At 9:37 a.m., ULP-B went back to the medication cart and opened up the MAR. The surveyor asked where ammonium lactate would be found ULP-B was unable to locate the ammonium lactate. The surveyor identified nystatin powder (anti-fungal) on the MAR and asked ULP-B if the powder was applied. -At 9:45 a.m., ULP-B located the nystatin powder and brought R2 back into the bathroom to apply. R2's record included prescriber orders dated September 18, 2025, indicating to increase Lexapro (escitalopram-major depressive disorder) to 10 milligrams (mg) by mouth (po) daily.	01760		

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01760	Continued From page 24 R2's Physician Order Sheet (listed all medications for R2) signed by provider on September 23, 2025, included the following medication orders: -escitalopram 10 mg tablet, take one tablet by mouth once daily; -escitalopram 5 mg tablet, take one tablet by mouth once daily; -nystatin 100000 unit/gram (gm) powder, apply topically two times daily; and -critic-aid barrier top paste-apply topically to peri area and buttocks as needed for skin irritation. R2 lacked a provider order for ammonium lactate. R2's MAR for September 1, 2025, through September 30, 2025, indicated the following medications were administered: -escitalopram 10 mg tablet, take one tablet by mouth once daily: September 20-23, at 8:00 a.m.; -escitalopram 5 mg tablet, take one tablet by mouth once daily: September 1 through 23 at 8:00 a.m.; -nystatin 100000 unit/gram (gm) powder, apply thin layer twice daily: September 1-22, at 10:00 a.m., and 9:00 p.m.; -critic-aid barrier top paste, apply topically to peri area and buttocks as needed for skin irritation: not documented as administered; -ammonium lactate was not included on the MAR. On September 23, 2025, at 2:35 p.m., CNS-A stated staff were required to check the MAR prior to administering medications, but he was not aware of R2's ammonium lactate. On September 24, 2025, at 12:45 p.m., the	01760		

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01760	Continued From page 25 surveyor met ULP-E at the medication cart to review R2's medications. R2's escitalopram pills were stored in individual bubble packs which contained 28 pills, one per bubble. The following was observed: -escitalopram 10 mg tablet, dispensed on September 18, 2025, indicated one pill was released September 21, through September 24, 2025; and -escitalopram 5 mg tablet, dispensed on September 3, 2025, indicated one pill was released September 12, through September 24, 2025. On September 24, 2025, at 1:00 p.m., CNS-A was unaware both doses of escitalopram were being given and stated that was happening. At 2:20 p.m., CNS-A provided the surveyor R2's signed Physician Order Sheet dated September 19, 2025, shown above, and indicated the provider had signed it indicating both doses were current, but the surveyor referred to the order dated September 18, 2025, shown above, which indicated the provider ordered to increase the escitalopram to 10 mg daily. CNS-A stated it was possible he forgot to discontinue the 5 mg dose before providing the physician order sheet to sign but needed to get clarification from the provider first. ULP-B's ULP Training and Competency Checklist dated January 22, 2025, indicated ULP-B was trained on topical medications: ointments, creams, powders, but lacked documented competency by the registered nurse. The licensee's Individualized Medication, Treatment & Therapy Management Plans policy dated May 24, 2022, indicated medication	01760		

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	40883	A. BUILDING: _____ B. WING _____	09/25/2025

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01760	Continued From page 26 management plans would be current and updated when there were changes. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 1, 2021, stated prior to preparing medication, the ULP would check the resident's MAR and medications always need to be administered according to the follow the "6 rights" which included: - right person - right medication - right time - right route - right dose - right chart/record to document that the medication was taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.	01910		

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01910	Continued From page 27 (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication in for one of two discharged 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's Discharge Summary dated July 3, 2025, indicated R1 was admitted to the licensee on May 14, 2025, and discharged on July 3, 2025, to another facility out of state. A final summary of resident's status indicated clinical nurse supervisor (CNS)-A filled a medication organizer for five (5) days and the medications were provided to resident, or their representative. R1's record lacked evidence of documentation of disposition of medications to include the medication's name, strength, prescription number	01910		

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01910	Continued From page 28 as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On September 25, 2025, at 1:22 p.m., CNS-A stated they provided the family with all of R1's medications and it was their process to document the name, quantity, prescription number, and have resident/family sign the form. It was not done at that time. The licensee's Disposition or Disposal of Medication policy revised July 23, 2021, indicated upon termination of medication management services, a resident's current medication that were secured or stored by the licensee would be given to the resident or the resident's representative. Staff would document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.	02320		

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02320	Continued From page 29 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to policy and accepted standards of practice by one of two unlicensed personnel (ULP)-B observed administrating medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 had diagnoses including chronic kidney disease, type 2 diabetes, weakness, and high blood pressure. R2's Exhibit D: Service Agreement signed September 22, 2025, indicated R2 received assistance with medication administration and blood glucose checks and monitoring. R2's prescriber orders dated September 19, 2025, ordered diclofenac sodium gel 1%, apply 2 grams topically to left thumb/wrist three times daily for pain. During observation on September 23, 2025, at 9:15 a.m., ULP-B went to the medication cart in the hallway and met clinical nurse supervisor	02320		

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02320	Continued From page 30 (CNS)-A who had just finished setting up R2's oral medications and had them in a medication cup ready for ULP-B to administer. CNS-A stated the insulin and eye drops also needed to be given. ULP-B accessed R2's electronic medication administration record (EMAR) and noted Novolin insulin, give 5 units SQ every morning for diabetes, Timolol 0.5% ophthalmic solution, one drop in both eyes daily for eye pressure, and diclofenac sodium gel 1%, apply 2 grams topically to left thumb/wrist three times daily for pain. ULP-B applied gloves, applied a pea-sized amount of gel to R2's wrist/thumb then applied another pea-sided amount of gel and place it on R2's right wrist/thumb. ULP-B's Unlicensed Personnel Training and Competency Checklist-Medication Administration Orientation dated January 22, 2025, indicated ULP-B was trained on "Topical Medications: Ointments, Creams, powders" by placing an "x" as completed within the "In-person Training completed" column but the column under "Skills Competency Completed" was blank or greyed out. During interview on September 23, 2025, at 10:10 a.m., regional director of clinical operations (RDCO)-D provided records and asked if ULP-B had used the dosing strip (measuring guide that comes with medication box) for the diclofenac cream, the surveyor said no, and RDCO-D appeared surprised and stated they would need to do re-training. During interview on September 24, 2025, at 1:16 p.m., director of training (DOT)-J explained ULP-B's training and competency form were old and not currently in use. DOT-J stated the	02320		

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02320	Continued From page 31 sections that were blank/greyed out meant certain routes could not be competency checked by her but should have been done by the facility registered nurse (RN). DOT-J stated she demonstrated to staff how to use the measuring guide for topical diclofenac. During interview on September 24, 2025, at 2:58 p.m., CNS-A stated he would watch ULPs complete medication administration prior to being on their own but did not document the competency. He also stated DOT-J would message CNS-A indicating what trainings/competencies needed to be completed at the facility. The diclofenac sodium topical gel 1 % manufacturer's instructions dated November 2024, indicated to always use the dosing card to measure the correct dose of diclofenac gel. The licensee's Administration of Medication, Treatment and Therapy By Unlicensed Personnel policy dated August 1, 2021, indicated medications, treatment and therapy always need to be administered according to the "6 Rights:" -Right person -Right medication, treatment or therapy -Right time -Right route (by mouth, eye drops, to the skin, etc.) -Right dose (how many milligrams, drops, etc.) -Right chart/record to document that the medication, treatment and therapy was taken. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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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

CARETTA SENIOR LIVING MAPLEWOO
1910 COUNTY ROAD C EAST
Maplewood, MN 55109
Ramsey County
Parcel:

Phone:

License Info

License: HFID 40883

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1021251148
Inspection Type: Full - Single
Date: 9/23/2025 Time: 10:31:29 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

Establishment has contracted a food service company, Unidine, to manage their food service operations. All kitchen staff are employed by Unidine. This kitchen is part of the same establishment as the facility located at 1890 County Road C East. Although the building has two different addresses, it is a single shared facility.

Unidine holds a license with the City of Maplewood. No inspection conducted by MDH.

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 F1021251148 from 9/23/2025

Establishment Representative

Melissa Ramos,
Public Health Sanitarian 3
651-201-4495
melissa.ramos@state.mn.us