



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF INITIAL LICENSE DENIAL

Electronically Delivered

October 22, 2025

Licensee

Maplewood Assisted Living Inc
1799 Edgerton Street
Maplewood, MN 55117

RE: Denial of License Number 418260
Health Facility Identification Number (HFID) 40848
Initial survey; Project Number SL40848015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on September 18, 2025, for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above-mentioned provider. Based on the survey(s), MDH found you not in substantial compliance with the laws pursuant to Minnesota Statute, Chapter 144G. As a result, your authority to continue to operate under a provisional license or be approved for an assisted living facility license is being denied.

STATE CORRECTION ORDERS

The enclosed State Form documents the state licensing orders. The Department of Health documents state 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 . . ."

REQUEST FOR RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.16, Subd. 4, you may request a reconsideration by the Minnesota Department of Health. The request for reconsideration process must be conducted internally by the Minnesota Department of Health and Chapter 14 does not apply. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

Note requests for reconsideration must be received by the department within 15 calendar days of the date of this notice.

REQUIREMENTS FOR NOTIFICATION AND TRANSFER OF RESIDENTS

You must comply with the requirements for notification and coordinated move of residents noted in Minn. Stat. § 144G.52 and Minn. Stat. § 144G.55. Additionally, please provide the information described in Minn. Stat. § 144G.20, Subd. 15 (a) (1), (2), (3), (4) and (5) to this department's contact, Renee L. Anderson, via email at: 651-201-5871. Also provide this information to the lead agencies as defined in section 256B.0911, county adult protection and case managers, and the ombudsman for long-term care no later than **October 25, 2025**.

Pursuant to Minn. Stat § 144G.16, Subd. 5 (3), a provisional licensee whose license is denied is permitted to continue operating as an assisted living facility during the period of time when a transfer of assisted living facility resident(s) from the provisional licensee to a new assisted living facility provider is in process.

Additionally, pursuant to Minn. Stat. § 144G.16, Subd. 5 (1), you may continue operating during the reconsideration process.

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

If you have any additional questions, please do not hesitate to contact Renee L. Anderson, Supervisor, at Renee.L.Anderson@state.mn.us. Renee L. Anderson can also be reached by office phone at 651-201-5871.

Sincerely,



Rick Michals, J.D.

Executive Regional Operations Manager

Minnesota Department of Health

Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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: SL40848015-0 On September 15, 2025, through September 18, 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 2 residents; 2 receiving services under the Provisional Assisted Living Facility license. Upon supervisor review, on October 13, 2025, an immediate order was identified for SL40848015-0, tag identification 0110. Upon supervisor review, on October 14, 2025, an immediate order was identified for SL40848015-0, tag identification 1700.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 110 SS=I	144G.10 Subdivision 1a Assisted living director license required	0 110			

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: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports (BELTSS) and affiliated as the director of record with the board. This had the potential to affect all the licensee's residents, staff, and visitors. 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: The licensee's assisted living license was effective October 23, 2024. The licensee's Application for Provisional Assisted Living License, signed by owner (O)-A on September 2, 2023, indicated on page 6 that clinical nurse supervisor (CNS)-E was the licensed assisted living director (LALD) for the	0 110	The licensee provided a plan of correction appropriate to mitigate the immediacy of the order. The scope and severity remain the same.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
0 110	Continued From page 2 licensee. On July 30, 2024, the Department sent an email to O-A indicating the application was not yet complete due to additional information needed including a LALD, because CNS-E was not identified in the BELTSS database as holding a license as an assisted living director. On August 28, 2024, the licensee indicated via email reply to the Department that LALD-F was the LALD for the facility, and included the license number for LALD-F. During the entrance conference on September 15, 2025, at approximately 10:15 a.m., O-A stated they had submitted to BELTSS, an application for an assisted living director in-residency permit. O-A stated LALD-F was his mentor. On September 15, 2025, at 1:34 p.m., a representative of BELTSS, stated via email, "Unfortunately, the applicant did not apply for the correct application type if needing a permit. [O-A] does not have a permit as a result. He will need to contact BELTSS if a permit is needed to operate this facility." The BELTSS representative further stated they replied to O-A in May 2025, notifying that in order to become the Assisted Living Director In Residence he needed a different permit type, and had provided the instructions to complete the application. On September 16, 2025, at approximately 10:00 a.m., LALD-F stated via phone that he was not involved in the day-to-day operations of the licensee's facility.	0 110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
0 110	Continued From page 3 On September 16, 2025, the BELTSS database indicated LALD-F held a current LALD license, but was not the Director of Record for the licensee's health facility identification (HFID) at any time. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 110			
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide the Minnesota Department of Health (MDH) with accurate and truthful information on the Application for Assisted Living licensure, and further failed to provide truthful information during a survey, by falsifying the personnel record for two of two employees (owner (O)-A unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
0 330	Continued From page 4 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: APPLICATION FOR ASSISTED LIVING LICENSURE The licensee's Application for Provisional Assisted Living License, signed by O-A on September 2, 2023, indicated on page 6 that clinical nurse supervisor (CNS)-E was the assisted living director for the licensee. On July 30, 2024, the Department sent an email to O-A indicating the application was not yet complete due to additional information needed including a LALD, because CNS-E was not identified in the Minnesota Board of Executives for Long-Term Services and Supports (BELTSS) database as holding a license as an assisted living director. On September 17, at 9:15 a.m., CNS-E stated he was only working for the licensee for a brief period, and was not familiar with assisted living facility regulations. On August 28, 2024, the licensee indicated via email reply to the Department that LALD-F was the LALD for the facility, and included the license number for LALD-F. On September 16, 2025, at approximately 10:00 a.m., LALD-F stated via phone that he was not involved in the day to day operations of the	0 330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
0 330	Continued From page 5 facility. On September 16, 2025, the BELTSS database indicated LALD-F held a LALD license, but was not the Director of Record for the licensee at any time. TRAINING RECORDS O-A was hired October 1, 2024, and was the director of the facility and also provided direct care services for residents. ULP-D was hired January 11, 2025, and provided direct care services for residents. On September 16, 2025, at 8:30 a.m., the surveyor observed O-A assisting R1 with medication administration. On September 15, 2025, at 12:00 p.m., the surveyor requested the contact information for CNS-E. O-A stated that he no longer had the contact information. O-A further stated the number he had was no longer in service. O-A declined to provide the phone number. The surveyor located a phone number for CNS-E entered on the licensee's application for assisted living that was submitted to the department. On September 15, 2025, the surveyor called CNS-E at the identified number, and left a voicemail message requesting a call back. On September 16, 2025, at 3:49 p.m., O-A provided documentation of that he had completed the training. The documentation appeared to have the signature of CNS-E.	0 330			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
0 330	Continued From page 6 O-A and ULP-D's record had documentation that appeared to have CNS-E signature. O-A stated that all trainings were completed by CNS-E. On September 17, 2025, at 9:15 a.m., CNS-E returned the phone call to the surveyor. CNS-E stated he was the CNS for "a short time". He stated he provided some medication training when the licensee admitted their first resident. He denied training on personal care, dementia care or any other areas. He further stated that he had not signed any documentation regarding training staff. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			
0 420 SS=I	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the potential to affect all residents.	0 420			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
0 420	Continued From page 7 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: The licensee's assisted living license was effective October 23, 2024. On September 15, 2025, at approximately 10:35 a.m., owner (O)-A stated he was in charge of the day to day operation of the facility. O-A further stated he had applied for an assisted living director permit. O-A stated LALD-F was his mentor. On September 16, 2025, at approximately 10:00 a.m., LALD-F stated via phone that he was not involved in the day to day operations of the facility. On September 16, 2025, at 8:30 a.m., the surveyor observed O-A assisting R1 with medication administration. On September 15, 2025, at 10:45 a.m., O-A stated he had hired a new clinical nursing supervisor (CNS)-B. He further stated CNS-B had no previous experience with assisted living regulations. The licensee's "Application for Assisted Living License", signed by O-A on September 2, 2023, indicated on page 6 that CNS-E was the Assisted	0 420			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
0 420	Continued From page 8 Living Director for the licensee. No director license number was entered. Minnesota Board of Executives for Long Term Services and Supports (BELTSS) showed CNS-E had never held Assisted Living Director license. The application section titled "Official Verification of Owner or Authorized Agent", (page 17 and 18 of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page 18 was electronically signed by owner O-A on September 2, 2023. As a result of this survey, 25 orders were issued, including one level 4 order: 1700; five level 3 orders: 0110, 0420, 0775, 0780, and 1620; and 17 level 2 orders: 0330, 0480, 0510, 0550, 0630, 0730, 0800, 0810, 1370, 1380, 1440, 1530,	0 420			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
0 420	Continued From page 9 1640, 1730, 1760, 1820, 1890 and 2310; indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Two (2) days	0 420			
0 470 SS=C	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	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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 10 (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post a daily staff schedule in a central location. This had the potential to affect all residents and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 15, 2025, at 11:20 a.m., during a tour of the facility, the licensee's staff schedule could not be located in a central location. Owner (O)-A stated that schedule was not posted because he was not aware that it was required 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	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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 11 capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, 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	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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 12 breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 16, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
0 510	Continued From page 13 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 16, 2025, at 8:30 a.m., the surveyor observed owner (O)-A assisting R1 with medication administration. O-A accessed the	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
0 510	Continued From page 14 computer and written medication administration record (MAR), and prepared medication for R1. Without performing hand hygiene (HH), O-A entered R1's room and administered medication. O-A left room and returned to the office. O-A did not perform HH after leaving R1's room. On Septer 16, 2025, at 12:45 p.m., when asked when they would complete HH during care, O-A stated they performed HH after completing medication administration for all residents. The Centers for Disease Control and Prevention (CDC) guidance, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, revised November 29, 2022, indicated standard precautions were to be used to care for all patients (residents) in all settings, including HH, and noted, "Use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient. b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices. c. Before moving from work on a soiled body site to a clean body site on the same patient. d. After touching a patient or the patient's immediate environment. e. After contact with blood, body fluids or contaminated surfaces f. Immediately after glove removal." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
0 550	Continued From page 15	0 550			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure, including the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all residents receiving assisted living 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
0 550	Continued From page 16 of the residents). The findings include: On September 15, 2025, at 11:10 a.m., the surveyor observed the common area lacked a posted grievance procedure with contact information for individuals responsible for handling resident grievances. On September 15, 2025, at 11:15 p.m., owner (O)-A stated they were not aware that the grievance policy was required to be posted. The licensee's grievance posting policy, dated January 1, 2025, indicated the licensee, "will post, in a conspicuous place, information about our complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
0 630	Continued From page 17 taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for two of two residents (R1, 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 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's diagnoses included schizophrenia a mental health disorder. R1's unsigned service plan, dated September 16, 2025, indicated R1 received services including assistance with activities of daily living (ADLs), housekeeping, and medication management. R2's diagnoses included age related physical debility (physical decline related to age). R2's unsigned service plan, dated September 16, 2025, indicated R2 received services including assistance with ADLs, and housekeeping.	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
0 630	Continued From page 18 R1 and R2's records both lacked a IAPP including an individualized review of the susceptibility to abuse by another individual, including other vulnerable adults; risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On September 16, 2025, at 11:45 a.m., owner (O)-A stated they were unaware of the required content of IAPPs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
0 730	Continued From page 19 conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of all provided services for two of two residents (R1, 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	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
0 730	Continued From page 20 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1, R2's medical records lacked documentation of services received. R1's unsigned service plan, dated September 16, 2025, indicated R1 received services including assistance with dining-3x per day, housekeeping-daily, laundry-every 4 days, shopping assistance-weekly, smoking monitoring- 3 times a day. R2's unsigned service plan, dated September 16, 2025, indicated R2 received services for assistance with dining-3x per day, housekeeping-daily, laundry-every 4 days, shopping assistance-weekly, bathing assistance-daily, dressing-daily, incontinence care daily, behavior assistance daily. R1 and R2's medical record had no documentation of services provided. On September 16, 2025, at 12:40 p.m., owner (O)-A stated that the staff did not complete service charting. O-A stated he was not aware that it was required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 775	Continued From page 21	0 775			
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). On September 17, 2025, at approximately 12:00 p.m., the surveyor toured the facility with owner (O)-A. The following was observed. 1. A carbon monoxide alarm was not present on the main level. When carbon monoxide alarms are not tied into the building fire alarm system, carbon monoxide alarms are required to be installed within ten feet of all sleeping rooms. On September 17, 2025, O-A acknowledged the observation during the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms in required locations. These deficient conditions had the ability to affect all staff and residents. This practice resulted in a level three violation (a	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
0 780	Continued From page 23 violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 17, 2025, at approximately 12:00 p.m., the surveyor toured the facility with owner (O)-A. The following was observed. 1. A smoke alarm was not installed outside occupied resident bedroom 5 in the immediate vicinity of this sleeping area. 2. There was a hardwired smoke alarm missing outside in the hallways leading to the main level bedrooms. Smoke alarms are required to be maintained as hardwired (receiving power from the building electrical system) as installed at the time of construction in accordance with current Minnesota Fire Code. 3. During the tour, a test of the smoke alarms was conducted by O-A and it was observed that the smoke alarms in the facility were not interconnected. All smoke alarms are required to be interconnected so that the actuation of any one alarm causes all alarms within the facility to operate. The original hard wired smoke alarm in the hallways where not interconnected with the newer wireless interconnected smoke alarms. All dwelling units required to have multiple smoke alarms are required to have interconnected alarms so activation of one alarm activates all alarms within the dwelling unit. On September 17, 2025, O-A acknowledged the	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
0 780	Continued From page 24 observation during the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 25 The findings include: On September 17, 2025, at approximately 12:00 p.m., the surveyor toured the facility with owner (O)-A. The following was observed. GENERAL MAINTENANCE: The ceiling in bedroom 4 bathroom was damaged and heavily stained. O-A stated they had a leak in the bathroom above in the past that was repaired, but the ceiling had not been repaired yet. The flooring in the laundry room and bedroom 2 was heavily damaged and warped. This had the potential to compromise the use of the mobility devices that were observed during the tour. On September 17, 2025, O-A acknowledged the observation during the tour. TIME PERIOD FOR CORRECTION: Twenty One (21) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
0 810	Continued From page 26 or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
0 810	Continued From page 27 the residents). The findings include: On September 17, 2025, owner (O)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On September 17, 2025, O-A stated they	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
0 810	Continued From page 28 understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. O-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. O-A stated they have not offered training to residents. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. O-A stated that staff training was done in Educare and not on the facilities written FSEP. No other training documentation was provided. On September 17, 2025, O-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, revealed no evacuation drills were initiated with the overnight staff. O-A confirmed no evacuation drills have taken place with the overnight staff. No other documentation was provided. On September 17, 2025, O-A stated there were	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
0 810	Continued From page 29 no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
0 950	Continued From page 30 by: Based on interview and record review, the licensee failed to include, on a page separate from the contract, the required verbiage notifying the resident of their "Right to designate a representative..." and failed to identify a designated representative or document that the resident declined to designate a representative for one of one resident (R1). 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: R1's contract, dated February 12, 2025, lacked documentation that R1 was given the opportunity to designate a representative and lacked, on a page separate from the contract, the required verbiage notifying R1 of their "right to designate a representative for certain purposes." During an interview on September 15, 2025, at 1:15 p.m., owner (O)-A stated R1's record lacked the required verbiage related to identifying a designated representative. O-A stated the required verbiage was missing from all residents' contracts because they were not aware the verbiage was required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
01370	Continued From page 32 technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed with all required content for two of two employees (owner (O)-A and unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: O-A O-A was hired October 1, 2024, and provided direct care assisted living services for residents. On September 16, 2025, at 8:30 a.m., the surveyor observed O-A assisting R1 with medication administration. O-A's employee record lacked evidence O-A completed the required training and competency testing for all unlicensed personnel including: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control, including blood-borne pathogens;	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
01370	Continued From page 33 -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. On September 16, 2025, at 3:49 p.m., O-A provided documentation indicating he had completed the training. Some of the training documentation appeared to have the signature of clinical nurse supervisor (CNS)-E. ULP-D ULP-D was hired January 11, 2025, and provided direct care assisted living services for residents. ULP-D's employee record included	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
01370	Continued From page 34 documentation of training dates, but lacked evidence the indicated training or any competency testing was completed by the registered nurse, including the following: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: - hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; -training on the prevention of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. Several of ULP-D's training documents included	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
01370	Continued From page 35 an illegible signature lacking a signed date and no indication who provided the training or their credentials. Further, several of the training tests appeared to be an exact copy of the documents O-A submitted as his own training, including the following: -documentation requirements for all services provided; -reports of changes in the resident's condition to the supervisor designated by the facility; -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -training on the prevention of falls; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident's family; and -procedures to use in handling various emergency situations. On September 17, 2025, 9:30 a.m., CNS-E stated that he did not complete training with O-A or ULP-D on any personal care of residents. CNS-E further stated he had not signed any documents regarding training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
01380	Continued From page 36 competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency was completed with all required content for two of two employees (owner (O)-A and unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: O-A was hired October 1, 2024, and provided direct care assisted living services for residents.	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
01380	Continued From page 37 ULP-D was hired January 11, 2025, and provided direct care assisted living services for residents. On September 16, 2025, at 8:30 a.m., the surveyor observed O-A assisting R1 with medication administration. O-A and ULP-D's employee records lacked evidence of training and competency evaluations completed by the registered nurse (RN) for unlicensed personnel providing assisted living services including: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; and -administering medications or treatments as required. On September 16, 2025, at 3:49 p.m., O-A provided documentation indicating he had completed the training. Some of the documentation lacked identification of the name or credentials of the instructor. On the documents that appeared to have a signature, the instructor's name was illegible and the documentation lacked indication of competency testing. September 17, 2025, 9:30 a.m., CNS-E stated	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
01380	Continued From page 38 that he did not complete training with O-A or ULP-D on any personal care of residents. CNS-E further stated he had not signed any documents regarding training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
01440	Continued From page 39 by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) supervised unlicensed personnel (ULP), within 30 calendar days of beginning to provide delegated tasks, for two of two employees (owner (O)-A and ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: O-A was hired October 1, 2024, and provided direct care services for residents. ULP-D was hired January 11, 2025, and provided direct cares for residents. On September 16, 2025, at 8:30 a.m., the surveyor observed O-A assisting R1 with medication administration. O-A and ULP-D's employee files lacked documentation of direct supervision within 30 days of performing a task delegated by the RN. On September 15, 2025, at 12:30 p.m. clinical nurse supervisor (CNS)-D stated that she was new to working in assisted living and did not know what was required of the nurse and that she had not completed any supervision.	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
01440	Continued From page 40 The licensee's Supervision of Staff - Delegated Services policy, dated January 1, 2025, indicated RN supervision would be completed within 30 calendar days from the day the task was first delegated and would be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the	01460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
01460	Continued From page 41 facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations for one of two employees (owner (O)-A). 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: O-A was hired October 1, 2024, and provided direct care assisted living services for residents. On September 16, 2025, at 8:30 a.m., the surveyor observed O-A assisting R1 with medication administration. O-A's employee record lacked evidence O-A	01460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
01460	Continued From page 42 completed the required orientation including the following: -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee would be providing and the facility's category of licensure. On September 16, 2025, at 3:49 p.m., O-A provided documentation indicating he had completed the training. The above-listed documentation lacked an employee name and date of orientation. Further, the answers for the test portion of the training documents appeared to be a copy of the orientation documentation found in unlicensed personnel (ULP)-D's record. On September 17, 2025, 9:30 a.m., CNS-E	01460			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
01460	Continued From page 43 stated that he did not complete training with O-A or ULP-D on any personal care of residents. CNS-E further stated he had not signed any documents regarding training. A policy was requested and not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
01530	Continued From page 44 another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required dementia care training was completed for two of two employees ,(owner (O)-A, unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: O-A O-A was hired October 1, 2024, and provided	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
01530	Continued From page 45 direct care services for residents. On September 16, 2025, at 8:30 a.m., the surveyor observed O-A assisting R1 with medication administration. O-A's employee record lacked evidence of at least eight hours of initial dementia training within 160 working hours of the employment start date to include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. On September 16, 2025, at 10:45 a.m., O-A stated his employee file at home, but he had completed the training with former clinical nurse supervisor (CNS)-E. On September 16, 2025, at 3:49 p.m., O-A provided documentation of that he had completed the dementia training. The documentation appeared to have the signature of CNS-E, but lacked a date signed. The documentation further lacked documentation of the hours of training completed. ULP-D ULP-D was hired January 11, 2025, and provided direct cares for residents. ULP-D's employee record included documentation ULP-D completed training on the required dementia care topics. The documentation appeared to have the signature of	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
01530	Continued From page 46 CNS-E, but lacked a date signed. The documentation further lacked documentation of the hours of training completed. September 17, 2025, 9:30 a.m., CNS-E stated that he did not complete training with O-A and ULP-D on dementia care. CNS-E further stated he had not signed any documents regarding training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=I	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 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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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 47 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 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 ensure the registered nurse (RN) completed and/or documented an initial nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident, ongoing assessment no more than 14 calendar days after initiation of services, as needed based on changes in the resident's	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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 48 needs; and at least every 90 calendar days, to include required areas of assessment per Assisted Living Facilities: Minnesota Rules Chapter 4659, for two of two residents (R1 and R2). 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 February 12, 2025, and had diagnoses including schizophrenia (a mental health disorder). R1's unsigned service plan, dated September 16, 2025, indicated R1 received services including assistance with activities of daily living (ADLs), housekeeping, and medication management. R2 was admitted March 1, 2025, and had diagnoses including age related physical debility (physical decline related to age). R2 unsigned service plan, dated September 16, 2025, indicated R2 received services including assistance with ADLs, and housekeeping. R1 and R2's records lacked documentation of an initial comprehensive nursing assessment, a 14-day reassessment, and lacked any ongoing reassessments, not to exceed 90 days, including the required areas of assessment per Assisted	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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 49 Living Facilities: Minnesota Rules Chapter 4659. On September 15, 2025, at 11:00 a.m., owner (O)-A stated the RN saw the residents but did not complete an assessment because they did know one needed to be completed. O-A further stated that they did not have a assessment form to complete. On September 15, 2025, at 12:30 p.m. clinical nurse supervisor (CNS)-B stated that she was new to working in assisted living and did not know what was required of the nurse. The licensee's Comprehensive Assessment policy, January 1, 2025, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment. The Assisted Living Facilities: Minnesota Rules Chapter 4659.0150 Uniform Assessment Tool indicated: - Subpart 1. Definition. For purposed of this part, "Uniform Assessment Tool" means an assessment tool that meets the requirements of this part and is used by a licensee to comprehensively evaluate a resident's or prospective resident's physical, mental, and cognitive needs - Subp. 2. Assessment tool elements. Each facility must develop a uniform assessment tool. The facility may use any acceptable form or format for the tool, such as an online or a hard-copy paper assessment tool, as long as the tool includes the elements identified in this subpart. A uniform assessment tool must	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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 50 address the following: A. the resident's personal lifestyle preferences, including: (1) sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; (2) spiritual and cultural preferences; and (3) advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order or "physician/provider orders for life-sustaining treatment: order. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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 51 (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was developed, including a signature or other authentication by the licensee and by the resident documenting agreement on the services to be provided, for two of two residents (R1, 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 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's unsigned service plan, dated September 16, 2025, indicated R1 received services including assistance with activities of daily living (ADLs), housekeeping, and medication management. R2's unsigned service plan, dated September 16, 2025, indicated R2 received services including assistance with ADLs, and housekeeping.	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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 52 On September 2025, at 8:30 a.m., the surveyor observed owner (O)-A assist R1 with medication administration. R1 and R2's records lacked a service plan including a signature or other authentication by the facility and by the resident or their representative, documenting agreement on the services to be provided. On September 16, 2025, at 10:30 a.m., O-A stated they could not locate a signed service plan for R1and R2 because they did not know one was required. Surveyor informed O-A that the electronic medical record (EMR) may have a service that is created when resident data is inputted into the system. O-A was then able to locate and print a unsigned service plan from the EMR. A service plan policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01700 SS=L	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
01700	Continued From page 53 services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct a face-to-face assessment to determine what medication management services will be provided and how the services will be provided, for one of one resident (R1). This practice resulted in a level four violation (a violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death), and was issued at a widespread scope (when problems are pervasive or represent a	01700	The licensee provided a plan of correction appropriate to mitigate the immediacy of the order. The scope and severity remain the same.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
01700	Continued From page 54 systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted February 12, 2025, and had diagnoses including schizophrenia (a mental health disorder). R1's unsigned service plan, dated September 16, 2025, indicated R1 received services including assistance with activities of daily living, housekeeping, and medication management. R1's record lacked an initial assessment of medication management services. On September 16, 2025, at 8:40 a.m., the surveyor observed owner (O)-A assisting R1 with medication administration. R1's medication administration record (MAR) for September 14, 2025, indicated R1 was administered the following medications: -clonazepam (a controlled substance that may lead to physical dependence used to treat mental health and siezure disorders) 0.5 mg, by mouth twice a day, -olanzipine (an antipsychotic medication used to treat mental health disorders) 10 mg 1 tablet by mouth twice daily, -"insulin" (unspecified type, for diabetes) 24 units (u) under the skin daily, -lisinopril (for high blood pressure) 2.5 mg once daily, -clonidine (for high blood pressure) 0.3 mg 1 patch to skin weekly, -metformin (blood sugar) 1000 milligrams (mg) 1 tablet twice a day by mouth,	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
01700	Continued From page 55 -calcium carbonate (supplement) 600 mg 1 tablet by mouth twice daily, -multi-vitamin (supplement) pill by mouth daily, -Advair inhaler (for breathing) twice daily, -aspirin (blood thinner) 81 mg once a day, -vitamin D3 (supplement) 1000 u daily, -atorvastatin (for high cholesterol) 10 mg, by mouth daily, -montelukast (for decreased mucus) 10 mg, by mouth daily, and -melatonin (for sleep) 10 mg, by mouth daily. R1's record lacked an initial assessment of medication management services to include the following: - documentation the assessment was conducted face-to-face with the resident; - identification and review of all medications the resident is known to be taking, which included indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues; - identification of interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications On September 15, 2025, at 11:00 a.m., O-A stated the RN saw the residents but did not complete an assessment because they did know one needed to be completed. O-A further stated that they did not have a assessment form to complete. On September 15, 2025, at 12:30 p.m. clinical	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
01700	Continued From page 56 nurse supervisor (CNS)-B stated that she was new to working in assisted living and did not know what was required of the nurse. The licensee's Comprehensive Assessment policy, January 1, 2025, indicated the initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01700			
01730 SS=F	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;	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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 57 (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (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 a widespread scope (when problems are pervasive or represent a systemic	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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 58 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted for assisted living services on February 12, 2025. R1's diagnoses included history of schizophrenia and type two diabetes. R1's service plan, unsigned, dated September 16, 2025, indicated R1 received services including assistance with activities of daily living, housekeeping, and medication management. On September 16, 2025, at 8:40 a.m., the surveyor observed owner (O)-A assisting R1 with medication administration. R1's medication administration record (MAR) for September 14, 2025, indicated R1 was administered the following medications: -metformin (blood sugar) 1000 milligrams (mg) 1 tablet twice a day by mouth, -calcium carbonate (supplement) 600 mg 1 tablet by mouth twice daily, -multi-vitamin (supplement) pill by mouth daily, -olanzipine (for mental health) 10 mg 1 tablet by mouth twice daily, -Advair inhaler (for breathing) twice daily, -aspirin (blood thinner) 81 mg once a day, -clonidine (for blood pressure) 0.3 mg 1 patch to skin weekly, -vitamin D3 (supplement) 1000 units (u) daily, -insulin (for diabetes) 24 (u) under the skin at daily, -lisinopril (for high blood pressure) 2.5 mg once daily,	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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 59 -atorvastatin (for high cholesterol) 10 mg, by mouth daily, -montelukast (for decreased mucus) 10 mg, by mouth daily, -melatonin (for sleep) 10 mg, by mouth daily, and -clonazepam (for mental health) 0.5 mg, by mouth twice a day. R1's record lacked evidence of a medication management plan with the following required content: -a statement describing the medication management services that will be provided; -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -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. On September 16, 2025, at 10:40 a.m., O-A confirmed they did not have a medication management plan because they did not know that it was required.	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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 60 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure medications were administered per provider orders for one of one resident (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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 61 a large portion or all of the residents). The findings include: R1's service plan, unsigned dated September 16, 2025, including assistance with activities of daily living, housekeeping, and medication management. TRANSCRIPTION R1's medication administration record (MAR) for September 15, 2025, indicated R1 was administered medications including "Advair Inhaler" and "insulin 24 units". The MAR lacked the following: -Advair strength and dosage, -type of "insulin", strength and dosage. R1's medication list signed by the provider September 18th after the start of the survey indicated the following: -Advair, fluticasone proprion-salmeterol, 230-21 micrograms, administer 2 puffs twice a day -Xultophy, insulin degludec/liraglutide 100/3.6, inject 26 units subcutaneously once daily. On September 16, at 11:15 a.m., O-A stated they provided medication training and competency by a former clinical nurse supervisor (CNS)-E and was told to follow the MAR. September 17, 2025, 9:30 a.m., CNS-E stated that he did complete training on how to administer medication and did not complete any written documentation of the training. CNS-E futher stated they did create a MAR. No further information was provided.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01760	Continued From page 62	01760			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure there were current written or electronically recorded prescriptions as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility was managing for one of one 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 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's diagnoses included schizophrenia a mental health disorder. R1's service plan, unsigned, dated September 16, 2025, including assistance with activities of daily living, housekeeping, and medication	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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
01820	Continued From page 63 management. On September 16, 2025, at 8:40 a.m., the surveyor observed owner (O)-A assisting R1 with medication administration. R1's medication administration record (MAR) for September 15, 2025, indicated R1 was scheduled to take the following medications: -metformin (blood sugar) 1000 milligrams (mg) 1 tablet twice a day by mouth, -calcium carbonate (supplement) 600 mg 1 tablet by mouth twice daily, -multi-vitamin (supplement) pill by mouth daily, -olanzipine (for mental health) 10 mg 1 tablet by mouth twice daily, -Advair inhaler (for breathing) twice daily, - aspirin (blood thinner) 81 mg once a day, -clonidine (for blood pressure) 0.3 mg 1 patch to skin weekly, -D3 (supplement) 1000 units (u) daily, -insulin (for diabetes) 24 (u) under the skin at daily, -lisinopril (for high blood pressure) 2.5 mg once daily, -atorvastatin (for high cholesterol) 10 mg, by mouth daily, -montelukast (for decreased mucus) 10 mg, by mouth daily, -melatonin (for sleep) 10 mg, by mouth daily, and -clonazepam (for mental health) 0.5 mg, by mouth twice a day. R1 records lacked current signed provider orders for the above-listed medications at the time of survey. Owner (O)-A provided signed orders dated September 18, 2025 (after the survey began).	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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
01820	Continued From page 64 On September 16, 2025, at 1:30 p.m., O-A stated that they had signed orders but could not access them because they were in a digital fax system and they could not remember the password. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for 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 ensure medications were maintained including the opened date for time sensitive medication storage for one of one resident (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:	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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 65 R1's diagnoses included schizophrenia (a mental health disorder). R1's service plan, unsigned, dated September 16, 2025, indicated R1 received services including assistance with activities of daily living, housekeeping, and medication management. On September 16, 2025, at 8:40 a.m., the surveyor observed owner (O)-A assisting R1 with administering Xultophy 24 units (u) in right lower abdomen. R1's medication administration record (MAR) for September 15, 2025, indicated R1 was scheduled to take 24 u of "insulin" (a medication to control blood sugars) via injection pen, one time per day. R1 records lacked current signed provider orders for the above-listed medications at the time of survey. Owner (O)-A provided signed orders dated September 18, 2025 (after the survey began) stated R1 was ordered Xultophy (a long acting insulin to treat diabetes) 26 units daily. On September 16, 2025, at 10:00 a.m., during a review of the medication storage area, the surveyor observed R1 had one Xultophy insulin pen that was open and in-use. The pen lacked an opened date to indicate when the medication was first used and would expire. Manufacturer instructions for Xultophy, revised July 2023, indicated the medication should not be used longer than 21 days after the first injection. On September 16, 2025, at 10:10 a.m., O-A	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117		
(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 66 stated that they were not aware that open dates needed to be added to the insulin pen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
02310 SS=D	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 services that complied with accepted health care, medical, and nursing standards for infection control regarding handling sharps, for one of one employee (owner (O)-A). 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: O-A was hired October 1, 2024, and provided	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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 67 direct care services for residents. On September 16, 2025, at approximately 8:40 a.m., the surveyor observed O-A assisting R1 with medication administration. O-A removed an Xultophy (to treat diabetes) injection pen from the medication cabinet, added a needle to the pen and dialed the pen to 24 milligrams (mg). O-A handed the Xultophy to R1 who injected the right lower abdomen. O-A held the Xultophy pen in his right hand and pushed the soiled needle of the Xultophy pen into the needle cap held in her left hand. O-A removed the capped needle from the Xultophy pen and disposed of them the sharps container. O-A did not follow recommended safety and infection control measures while recapping a contaminated needle prior to disposing. On September 16, 2025 at 9:10 a.m., O-A stated that he was trained on injection administration by the nurse and was trained to dispose of the needle that way. Manufacturer instructions for Xultophy, revised July 2023, indicated to never recap a needle after use. The Centers of Disease Control and Prevention (CDC) guidance, "Workbook for Designing, Implementing & Evaluating a Sharps Injury Prevention Program" dated April 3, 2024, and the Occupational Health and Safety Administration (OSHA) Bloodborne Pathogens Standard indicated recapping needles is prohibited "unless the employer can demonstrate that no alternative is feasible, or that such action is required by a specific medical or dental procedure."	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40848	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/18/2025
NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1799 EDGERTON STREET MAPLEWOOD, MN 55117			
(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 68 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

MAPLEWOOD ASSISTED LIVING INC
1799 EDGERTON STREET
Maplewood, MN 55117
Ramsey County
Parcel:

Phone:

License Info

License: HFID 40848

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

Inspection Info

Report Number: F7963251049
Inspection Type: Full - Single
Date: 9/16/2025 Time: 12:57:04 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 3
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 2-100 Supervision

2-102.12AMN Priority Level: Priority 3 CFP#: 2

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

COMMENT: SULEYMAN KAWO HAS TAKEN AND PASSED A FOOD SAFETY COURSE BUT HAS NOT APPLIED FOR HIS MN CERTIFIED FOOD MANAGER CERTIFICATE. INFORMATION SENT WITH REPORT.

Comply By: 9/16/2025 Originally Issued On: 9/16/2025

New Order: 2-100 Supervision

2-103.11D,G,H,I,K,M Priority Level: Priority 2 CFP#: 1

MN Rule 4626.0035DGHIM The person in charge must ensure employees follow proper food handling procedures, including: effectively wash their hands; prevent cross-contamination of ready-to-eat food with bare hands by using suitable food utensils such as deli tissue, spatulas, tongs, single-use gloves, or proper dispensing equipment; properly cook TCS foods and verify cooking temperatures with a temperature measuring device; properly cool TCS foods that will not be held hot or consumed within 4 hours; maintain TCS foods at proper hot and cold holding temperatures; plumbing cross connection control, and properly sanitize cleaned multiuse equipment and utensils by monitoring the exposure time and concentration of the chemical sanitizing rinse solution, or by monitoring the exposure time and temperature for hot water sanitizing.

COMMENT: PERSON IN CHARGE IS NOT KNOWLEDGEABLE CONCERNING OPERATION OF A FOOD SERVICE. FACT SHEETS EMAILED TO OPERATOR.

Comply By: 9/16/2025 Originally Issued On: 9/16/2025

! 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 AVAILABLE TO REVIEW. BLANK LOG PROVIDED AT TIME OF INSPECTION.

Comply By: 9/16/2025 Originally Issued On: 9/16/2025

New Order: 2-500 Cleanup of Vomiting and Diarrheal Events

2-501.11 Priority Level: Priority 2 CFP#: 5

MN Rule 4626.0123 Provide employees with procedures to follow for cleanup of vomit or fecal matter in the establishment. The procedures must minimize the spread of contamination to food and surfaces within the facility, and minimize the exposure of employees and consumers to contamination.

COMMENT: NO VOMIT/FECAL CLEAN-UP PROCEDURE AVAILABLE FOR REVIEW. FACT SHEET LEFT ON SITE.

Comply By: 9/16/2025 Originally Issued On: 9/16/2025

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs3-302.11A(1) *Priority Level: Priority 1 CFP#: 15**MN Rule 4626.0235A(1)* Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: RAW SHELL EGGS STORED ABOVE READY TO EAT FOODS IN THE REFRIGERATOR. EGGS MOVED TO LOWEST DRAWER DURING INSPECTION. CORRECTED ON SITE.

*Comply By: 9/16/2025 Originally Issued On: 9/16/2025***! New Order: 3-500B Microbial Control: hot and cold holding**3-501.16A2 *Priority Level: Priority 1 CFP#: 22**MN Rule 4626.0395A2* Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COMMENT: MILK AND LUNCH MEATS FOUND ABOVE 41 DEG F. SEE DATA TABLE. ITEMS DISPOSED OF AT TIME OF INSPECTION.

*Comply By: 9/16/2025 Originally Issued On: 9/16/2025***New Order: 4-500 Equipment Maintenance and Operation**4-501.11AB *Priority Level: Priority 3 CFP#: 47**MN Rule 4626.0735AB* All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

COMMENT: REFRIGERATOR NOT HOLDING A TEMPERATURE OF 41 DEG F OR COLDER. REPAIR/ADJUST. OPERATOR ADJUSTED THE REFRIGERATOR TEMP DURING INSPECTION.

*Comply By: 9/16/2025 Originally Issued On: 9/16/2025***New Order: 6-300 Physical Facility Numbers and Capacities**6-301.12 *Priority Level: Priority 2 CFP#: 10**MN Rule 4626.1445* Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

COMMENT: MISSING PAPER TOWELS AT HAND SINK. CORRECTED ON SITE.

*Comply By: 9/16/2025 Originally Issued On: 9/16/2025***New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control**6-501.111ABD *Priority Level: Priority 3 CFP#: 38**MN Rule 4626.1565ABD* Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

COMMENT: FOUND EVIDENCE OF MOUSE ACTIVITY (DROPPINGS) IN LOWER LEVEL KITCHEN. ESTABLISHMENT REPRESENTATIVE STATES THIS KITCHEN IS NOT USED FOR CLIENT FOOD PREPARATION OR STORAGE.

ESTABLISHMENT IS AWARE OF PROBLEM AND HAVE RECEIVED SERVICE FROM GREENIX PEST COMPANY.

CONTINUE CONTROLLING PEST ACTIVITY AND CLEAN UP AREAS WHERE MICE HAVE BEEN ACTIVE.

Comply By: 9/16/2025 Originally Issued On: 9/16/2025

Food & Beverage General Comment

MET WITH ESTABLISHMENT REPRESENTATIVE SULEYMAN KAWO AND MDH NURSE SURVEYOR ANGEL WOEHLER. THIS IS A RESIDENTIAL HOME USING HOUSEHOLD COOKING EQUIPMENT, REFRIGERATOR AND DISHWASHER. THEY DO SAME-DAY FOOD SERVICE. WE DISCUSSED THE FOLLOWING-

- EMPLOYEE ILLNESS POLICT AND LOG
- CERTIFIED FOOD MANAGER CERTIFICATE REQUIREMENTS
- HANDWASHING SUPPLIES
- STORAGE OF RAW SHELL EGGS
- PEST CONTROL OF MICE
- COLD HOLDING OF FOODS

THERE IS A SECOND KITCHEN IN THE LOWER LEVEL THAT IS NOT CURRENTLY BEING USED.

THE KITCHEN HAS LINOLEUM FLOORING, TILE COUNTERTOPS, WOOD CABINETS AND PAINTED CEILING.

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 F7963251049 from 9/16/2025



Suleyman Kawo

Peggy Spadafore,
Public Health Sanitarian Supervisor
651-201-3979
peggy.spadafore@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

MAPLEWOOD ASSISTED LIVING INC
Maplewood
County/Group: Ramsey County

Inspection Info

Report Number: F7963251049
Inspection Type: Full
Date: 9/16/2025
Time: 12:57:04 PM

Food Temperature: Product/Item/Unit: LUNCH MEATS; Temperature Process:

Location: REFRIGERATOR at 43 Degrees F.

Comment:

Violation Issued?: Yes

Food Temperature: Product/Item/Unit: MILK; Temperature Process:

Location: REFRIGERATOR at 47 Degrees F.

Comment:

Violation Issued?: Yes

Food Temperature: Product/Item/Unit: MILK; Temperature Process:

Location: REFRIGERATOR at 46 Degrees F.

Comment:

Violation Issued?: Yes



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
MAPLEWOOD ASSISTED LIVING INC	Report Number: F7963251049
Maplewood	Inspection Type: Full
County/Group: Ramsey County	Date: 9/16/2025
	Time: 12:57:04 PM

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

Location: DISHWASHER RINSE **Equal To** 160 Degrees F.

Comment:

Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F7963251049		Food Establishment Inspection Report		Page 1 of 1					
 Metro District Office Minnesota Department of Health 625 Robert St N, PO BOX 64975 St Paul, MN 55164		No. of Risk Factor/Intervention/Violations		7	Date: 9/16/2025				
		No. of Repeat Risk Factor/Intervention/Violations			Time: 12:57:04 PM				
		Score (optional)			Dur: min				
Establishment: MAPLEWOOD ASSISTED LIVING INC		Address: 1799 EDGERTON STREET		City/State: Maplewood, MN	Zip: 55117	Phone:			
License/Permit #: HFID 40848		Permit Holder:		Purpose of Inspection: Full	Est. Type:	Risk Category:			
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS									
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable				Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation					
Compliance Status			COS	R	Compliance Status		COS	R	
Supervision					Time/Temperature Control for Safety				
1	OUT	Person in charge present, demonstrate knowledge and performs duties			18	N/O	Proper cooking time & temperatures		
2	OUT	Certified Food Protection Manager			19	N/O	Proper reheating procedures for hot holding		
Employee Health					20	N/O	Proper cooling time and temperature		
3	OUT	knowledge, responsibilities, and reporting			21	N/O	Proper hot holding temperatures		
4	IN	Proper use of restriction and exclusion			22	OUT	Proper cold holding temperatures		
5	OUT	Response to vomiting, diarrheal events			23	IN	Proper date marking & disposition		
Good Hygienic Practices					24	N/A	Time as public health control;procedures & record		
6	IN	Proper eating, tasting, drinking, tobacco use			Consumer Advisory				
7	IN	No discharge from eyes, nose, and mouth			25	N/A	Consumer advisory provided for raw or undercooked foods		
Preventing Contamination by Hands					Highly Susceptible Populations				
8	IN	Hands clean and properly washed			26	IN	Pasteurized foods used; prohibited foods not offered		
9	IN	No bare hand contact with RTE foods, alternatives			Food/Color Additives and Toxic Substances				
10	OUT	Adequate handwashing sinks supplied and access			27	N/A	Food additives; approved & properly used		
Approved Source					28	N/A	Toxic substances properly identified;stored;used		
11	IN	Food obtained from approved source			Conformance with Approved Procedures				
12	N/O	Food Received at proper temperature			29	N/A	Compliance with variance, specialized processes & HACCP plan		
13	IN	Food in good condition, safe & unadulterated			Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health interventions are control measures to prevent foodborne illness or injury				
14	N/A	Records available: shellstock tags, parasite dest.							
Protection From Contamination									
15	OUT	Food separated and protected							
16	IN	Food-contact surfaces; cleaned & sanitized							
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food							
GOOD RETAIL PRACTICES									
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.									
Mark "X" or OUT in box if numbered item is not in compliance			Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation						
			COS	R				COS	R
Safe Food and Water					Proper Use of Utensils				
30	N/A	Pasteurized eggs used where required			43		In-use utensils; Properly stored		
31		Water & ice from approved source			44		Utensils, equipment & linens; properly stored, dried, handled		
32	N/A	Variance obtained for specialized processing methods			45		Single-use & single-service articles, properly stored and used		
Food Temperature Control					46		Gloves used properly		
33		Proper cooling methods used; adequate equipment for temperature control			Utensils, Equipment and Vending				
34	N/O	Plant food properly cooked for hot holding			47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
35	N/O	Approved thawing methods used			48		Warewashing facilities: installed, maintained, used; test strips		
36		Thermometers provided & accurate			49		Non-food contact surfaces clean		
Food Identification					Physical Facilities				
37		Food properly labeled; original container			50		Hot & cold water available; adequate pressure		
Prevention of Food Contamination					51		Plumbing installed; proper backflow devices		
38	X	Insects, rodents, & animals not present; no unauthorized person			52		Sewage & waste water properly disposed		
39		Contamination prevented during food prep, storage, & display			53		Toilet facilities; properly constructed, supplied & cleaned		
40		Personal cleanliness			54		Garbage & refuse properly disposed; facilities maintained		
41		Wiping cloths: properly used & stored			55		Physical facilities installed, maintained & clean		
42		Washing fruits & vegetables			56		Adequate ventilation & lighting; designated areas used		
Person in Charge (signature)				Person in Charge (signature)					
Inspector (signature)				Inspector (signature)					
Follow-up:				Follow-up Date:					