Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 21, 2025

Licensee
Maplewood Manor LLC
1010 1st Street Northeast
Elbow Lake, MN 56531

RE: Project Number(s) SL36368016

Dear Licensee:

On May 27, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on March 5, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

Electronically Delivered

April 3, 2025

Licensee
Maplewood Manor LLC
1010 1st Street Northeast
Elbow Lake, MN 56531

RE: Project Number(s) SL36368016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 5, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36368	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD MANOR LLC	1010 1ST STREET NE ELBOW LAKE, MN 56531

(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 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: SL36368016-0 On March 3, 2025, through March 5, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 13 residents; 13 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate correction order was issued on March 4, 2025, at a level 3/Widespread (I). The licensee took immediate action to mitigate the risk; however, scope and level remains at I.	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.	
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management	0 580		

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0 580	Continued From page 1 appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of a quality management activity appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all 13 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 the residents). The findings include: During the entrance conference on February 3, 2025, at 9:30 a.m., the surveyor requested the quality management plan, policy, and documentation from the last twelve months from assisted living director in residency (ALDIR)-A	0 580		

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0 580	Continued From page 2 and clinical nurse supervisor (CNS)-B. ALDIR-A stated ALDIR-A was unaware if the licensee had a quality management plan. ALDIR-A stated she was currently in training. CNS-B stated she began employment in December 2024, and was unsure if the the licensee has had a quality management plan. On February 4, 2025, at 2:20 p.m., ALDIR-A stated she was unable to locate a quality management plan or meeting notes. ALDIR-A stated being unaware of the quality management plan requirement. The licensee's Quality Improvement Project policy dated August 1, 2021, indicated the assisted living provider shall engage in quality management appropriate to the size of the assisted living provider and relevant to the type of services the assisted living provider provides. The quality management activity means evaluating the quality of care periodically reviewing residents services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, and other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to surveyors at the time of the survey investigation or renewal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		

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0 660	Continued From page 3	0 660		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included completion of a facility risk assessment. 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 of the residents). The findings include:	0 660		

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0 660	Continued From page 4 During the entrance conference on March 3, 2025, at 9:30 a.m., the surveyor requested to review the completed TB facility risk assessment. On March 3, 2025, at 12:30 p.m., clinical nurse supervisor (CNS)-B and the surveyor reviewed the licensee's TB Risk Assessment completed on August 15, 2023. CNS-B stated the risk assessment should be completed annually. CNS-B stated CNS-B started employment December 2024, and was unaware it had not been completed in 2024. The licensee's TB Plan, Staff Screening, Resident Assessment policy dated August 1, 2021, indicated the community will complete a written TB risk assessment and update the assessment data on an annual basis. Use the 'Community TB Risk Assessment Worksheet' for Health Care Settings Licensed by the Minnesota Department of Health (MDH). Use results from the community TB risk assessment to determine the community risk classification: low risk, medium risk, potential ongoing transmission. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	0 680		

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0 680	Continued From page 5 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to review the missing resident plan at least quarterly. This had the potential to affect all residents, staff, and visitors of the facility. 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 of the residents). The findings include: On March 4, 2025, at 1:45 p.m., the surveyor	0 680		

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0 680	Continued From page 6 reviewed the licensee's Emergency Preparedness Plan (EPP), last reviewed by the licensee on June 3, 2024. The missing resident policy was not reviewed quarterly. On March 4, 2025, at 2:17 p.m., assisted living director in residency (ALDIR)-A stated the policy was not reviewed quarterly. ALDIR-A stated the licensee had a missing person drill on September 30, 2024. ALDIR-A was not aware the missing resident policy needed to be reviewed quarterly. The Missing Resident/Elopement of Resident policy revised on April 1, 2022, indicated the community would review the policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the licensed assisted living director (LALD) and clinical nurse supervisor (CNS) must review the missing resident plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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;	0 810		

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0 810	Continued From page 7 (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. 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. 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	0 810		

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0 810	Continued From page 8 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 March 04, 2025, at 10:37 a.m., assisted living director in residency (ALDIR)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The FSEP (fire safety and evacuation plan) 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) and was very basic. The provided FSEP was a general guidance for fire response including responding to a fire alarm, activating the RACE and Pass systems but did not provide specific employee and resident actions to take in the event of a fire or similar emergency geared to this facility. ALDIR-A stated that she understood the plans requirements and that she would work on getting this up to date. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly	01290		

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01290	Continued From page 9 scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was completed for three of three employees (unlicensed personnel (ULP)-D, ULP-E, ULP-F). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: This resulted in an immediate correction order issued on March 4, 2025. During the entrance conference on March 3, 2025, at 9:30 a.m., assisted living director in	01290		

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01290	Continued From page 10 residency (ALDIR)-A stated ALDIR-A was aware of the required contents of employee records. ULP-D ULP-D was hired July 24, 2023, and began providing services to the assisted living residents. ULP-D's employee record lacked a cleared background study. ULP-D's timecard dated February 2, 2025, through March 3, 2025, indicated the ULP-D worked approximately 78.81 hours during this time with the licensees residents. ULP-E ULP-E was hired September 24, 2024, and began providing services to the assisted living residents. ULP-E's employee record lacked a cleared background study. ULP-E's timecard dated January 27, 2025, through March 1, 2025, indicated the ULP-E worked approximately 143.82 hours during this time with the licensees residents. ULP-F ULP-F was hired November 12, 2024, and began providing services to the assisted living residents. ULP-E's employee record lacked a cleared background study. ULP-F's timecard dated February 2, 2025, through February 7, 2025, indicated the ULP-F worked approximately 23.19 hours during this time with the licensees residents. The licensee's NETStudy 2.0 Roster for health facility identification (HFID) 36368 printed on March 3, 2025, indicated ULP-D, ULP-E and ULP-F lacked a background study.	01290		

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01290	Continued From page 11 On March 3, 2025, at 3:15 p.m., ALDIR-A stated ULP-D, ULP-E, and ULP-F did not have cleared background studies, she was not sure why these were missed. ALDIR-A stated ULP-D, ULP-E, and ULP-F have been taken off the staff schedule until the background studies were completed. On March 3, 2025, at 3:25 p.m., ALDIR-A and regional supervisor (RS)-G were informed by the surveyor she had notified her supervisor and would be addressing the missing background studies on March 4, 2025. ALDIR-A and RS-G agreed to wait and address on March 4, 2025, as the licensee had removed ULP-D, ULP-E and ULP-F from the staff schedule. The licensee's Background Check policy dated August 1, 2021, indicated the community will conduct a Minnesota Department of Human Services Background Study on all staff of community who will have independent, unsupervised contact with tenants or residents of community. No employee may have independent direct contact with any tenants or residents until acceptable result of the background study have been received. The community will not employ individuals whose results of the background study indicate disqualification for the position. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action to mitigate the risk; however, the scop and level remains at I.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36368	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD MANOR LLC	1010 1ST STREET NE ELBOW LAKE, MN 56531

(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 12	01890		
01890 SS=E	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 date time-sensitive medications with opened and expiration dates for two of two residents (R3, R4) whose medications were stored by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On February 3, 2025, from 11:00 a.m. to 11:10 a.m., the surveyor observed the licensee's medication storage cart in the dementia care unit with clinical nurse supervisor (CNS)-B. CNS-B stated staff were trained to date time sensitive medications, including inhalers. CNS-B stated CNS-B audits the medications regularly. CNS-B confirmed the following:	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36368	A. BUILDING: _____ B. WING _____	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD MANOR LLC	1010 1ST STREET NE ELBOW LAKE, MN 56531

(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 13 -R3's opened Anoro Ellipta 62.5 milligram (mg)/24 microgram (mcg), used to treat lung diseases lacked an open and expiration date; and -R4's opened Symbicort 160 mcg/4.5 mcg used to treat lung disease lacked an expiration date. The manufacturer's instructions for Anora Ellipta dated August 2025, indicated once the tray is opened, the inhaler can be used for up to six weeks, starting from the date of opening the tray. Write the date the inhaler should be thrown away on the label in the space provided. The date should be added as soon as the inhaler has been removed from the tray. The manufacturer's instructions for Symbicort inhaler dated February 2021, indicated once the inhaler is opened to discard after three months. The licensee's Storage of Medications policy dated August 1, 2021, indicated once opened, medications need to be labeled and dated with the open date, expiration date, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: *03/03/25*
Time: 13:42:55
Report: 7935251029

Food and Beverage Establishment Inspection Report

Location:
Maplewood Manor Llc
1010 1st Street Ne
Elbow Lake, MN56531
Grant County, 26

Establishment Info:
ID #: 0038006
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2186853600
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.
SERVSAFE CERTIFICATE POSTED. POST STATE CERTIFICATE.
Comply By: 03/03/25

Surface and Equipment Sanitizers

Hot Water: = at 170 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Quaternary Ammonia: = 200 ppm at Degrees Fahrenheit
Location: Sanitizing Bucket
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Three Comp Sink
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: Walk In
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Type: Full
Date: *03/03/25*
Time: 13:42:55
Report: 7935251029
Maplewood Manor Llc

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	1

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the MN Department of Health inspection report number 7935251029 of 03/03/25.

Certified Food Protection Manager: Jakimba Macheel

Certification Number: _____ Expires: 07/25/28

Signed: _____
Establishment Representative

Signed: Rebecca Tonneson
Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us