Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 8, 2025

Administrator
Haven Homes of Maple Plain

4848 GATEWAY BLVD
MAPLE PLAIN, MN 55359

RE: CCN: 245497
Cycle Start Date: July 24, 2025

Dear Administrator:

On July 24, 2025, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417).
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued, and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 24, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by

the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 24, 2026 (six months after the identification of noncompliance), your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department’s informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division

445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
PO Box 64975 | 625 Robert Street North
St. Paul, MN 55164-0975
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245497	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven Homes Of Maple Plain	4848 GATEWAY BLVD , MAPLE PLAIN, Minnesota, 55359

(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) COMPLETION DATE
E0000	Initial Comments On 7/21/25 through 7/24/25, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		08/15/2025
F0000	INITIAL COMMENTS On 7/21/25 through 7/24/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: NO deficiencies were cited. H54979107C/MN0011469 H54979690C/MN00111929 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		08/15/2025
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F0657	It is the policy of Cassia Haven Homes to comply with 42 CFR §483.21(b)(1)-(3), Comprehensive Care Plans. To assure continued compliance, the following plan has	09/05/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0657 SS = D	Continued from page 1 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to complete quarterly care conferences for 1 of 1 residents (R17) reviewed for care conferences. R17's annual minimum data set (MDS) dated 5/9/25, included R17 was cognitively intact and had diagnoses of cerebral palsy (a disorder that affects movement, muscle tone and posture) and anxiety disorder. R17's last completed care conference summary assessment was dated 11/25/24 and included R17 and family were in attendance. During interview on 7/21/25 at 6:17 p.m., R17 stated she did not remember having a care conference in March or June and that she could not remember the last time	F0657	Continued from page 1 been put into place: The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: The resident identified was immediately reviewed and their comprehensive care plan was up to date. All required elements were included and accurately documented. A care conference was scheduled for and held on 8/6/25. Actions taken to identify other potential residents having similar occurrences: Reviewed care conference schedule and audited last care conference dates for all current residents. All are up to date, Measures put in place to ensure deficient practice does not recur: Staff responsible for care conference scheduling received re-education on care conference requirements. Effective implementation of actions will be monitored by: The facility will audit 10 residents per month for three months to ensure compliance with care conferences. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. The person responsible to maintain compliance is: Director of Nursing or designee.	

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F0657 SS = D	Continued from page 2 she had one. During interview on 7/22/25 at 3:33 p.m., social work designee (SSD)-A stated care conferences were held quarterly, annually and with any significant change. The care conferences were documented on an assessment form and in a progress note. SSD-A confirmed R17 had not had a for the last two quarters. During interview on 7/23/25 at 7:14 a.m., MDS coordinator stated she completed MDS assessments annually, quarterly and with significant changes. MDS coordinator stated she would meet with SSD-A to discuss when assessments are due so the social work department could schedule a care conference. During interview on 7/23/25 at 12:38 p.m., director of nursing (DON) stated care conferences should happen every 90 days, with significant changes or as needed. Notifications are typically mailed to families and residents would have a reminder posted in their rooms. DON confirmed that last documented care conference for R17 was on 11/25/24 and therefore was not completed every 90 days as required. DON stated it was important to complete care conferences as required to give residents a space to voice any concerns they had to update on any changes. Facility provided policy for care plans dated 3/10/25, included a resident's care plan would be updated and approved at a care conference with the family and resident representative in attendance.	F0657		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum,	F0880	It is the policy of Cassia Haven Homes to comply with 42 CFR §483.80 Infection Control. To assure continued compliance, the following plan has been put into place; The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: The nurse who performed improper hand hygiene during wound care on the affected resident was immediately reeducated and subsequent audits were completed. No further issues were identified. Actions taken to identify other potential residents having similar occurrences:	09/05/2025

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F0880 SS = D	Continued from page 3 the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F0880	Continued from page 3 Residents currently receiving wound care were observed to ensure proper hand hygiene was performed by staff before and after wound care as well as between glove changes during wound care. Measures put in place to ensure deficient practice does not recur: All nursing staff were re-educated on the importance of proper hand hygiene specifically during wound care. Effective implementation of actions will be monitored by: The facility will audit 3 wound care episodes weekly for three months to ensure proper hand hygiene is performed before and after wound care as well as between glove changes during wound care. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. The person responsible to maintain compliance is: Director of Nursing or designee.	

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F0880 SS = D	Continued from page 4 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to complete proper hand hygiene for 1 of 5 residents (R66) reviewed for wound care of a pressure ulcer. R66's current wound care order dated 5/22/24, included to remove old dressing and packing, cleanse wound bed by irrigating with saline wound wash, cut alginate AG (an absorbate dressing with silver) into ¼ inch ribbon and loosely pack wound including any undermining (the edge of the wound separates from the surrounding tissue creating a pocket), and cover with a bordered dressing. The dressing was ordered to be changed daily on the evening shift. During wound care observation on 7/22/25 at 3:45 p.m., registered nurse (RN)-B washed hands with soap and water prior to starting wound care and gathered supplies. RN-B removed the old soiled dressing, removed gloves, failed to complete hand hygiene, placed new gloves on hands and completed wound measurements and wound cleansing. RN-B again changed gloves without completing hand hygiene, placed alginate AG in wound bed and covered with a bordered dressing as ordered. RN-B removed gloves, dated wound dressing, then washed hands with soap and water. During interview on 7/22/25 at 4:00 p.m., RN-B stated she washes her hands before and after wound care. She would change her gloves after touching a dirty area. She would only wash her hands if they got dirty during wound care. During interview on 7/23/25 at 7:34 a.m., nurse manager RN-A stated hand hygiene should have been completed any time gloves were changed during wound care. RN-A stated gloves should have been changed any time they are soiled during wound care or any time a nurse goes from a dirty to clean task. This was important to prevent	F0880		

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F0880 SS = D	Continued from page 5 infection and to keep the area clean. During interview on 7/23/25 at 12:35 p.m., director of nursing (DON) stated hand hygiene should have been completed any time gloves are changed. Soap and water or alcohol-based hand sanitizer would have been appropriate to use for hand hygiene. DON stated this was important to prevent infection. Facility provided wound care policy dated 3/10/25, included to complete hand hygiene prior to starting wound care. Hand hygiene should have been performed when gloves were changed after removing the old dressing and again after cleansing the wound as ordered.	F0880		

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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 07/24/2025 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Haven Homes of Maple Plain was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18 New Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		08/15/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Haven Homes of Maple Plain is a 1-story building with a basement determined to be of Type V(111) construction. This facility is divided into 4 smoke compartments and shares a common 2-hour fire-rated wall with an assisted-living facility. The building is fully protected throughout by an automatic fire sprinkler system. It has a fire alarm system with smoke detection in the corridors and resident rooms monitored for automatic fire department notification The facility has a capacity of 64 beds and had a census of 63 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0345 SS = F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in	K0345	Brief description of corrective action or planned corrective action: A comprehensive sensitivity test is conducted and monitored on the fire alarm system constantly. The smoke detector units will send an out of sensitivity range alarm to the fire panel and alert the monitoring	09/05/2025

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K0345 SS = F	Continued from page 2 accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation, and staff interview, the facility failed to maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3.1, 14.4.5, 14.4.5.3. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/24/2025 at 9:53 AM, it was revealed during a review of available documentation that a detailed sensitivity report was not available for review. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K0345	Continued from page 2 company if the sensitivity is out of range. Sensitivity testing of all fire alarm detection devices will be performed annually by a certified technician. Results of each sensitivity test will be reviewed immediately upon completion to identify and address any out-of-range devices. A copy of this documentation will be kept in the fire log for review. Steps to prevent recurrence: Sensitivity testing of all fire alarm detection devices will be performed annually by a certified technician. Results of each sensitivity test will be reviewed immediately upon completion to identify and address any out-of-range devices. How the facility plans to monitor future performance to ensure solutions are sustained: The Maintenance Director will review sensitivity test reports after each annual test to confirm all devices are within required parameters. Person responsible for compliance: Maintenance Director	
K0346 SS = F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than four hours in a 24 hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility.	K0346	Brief description of corrective action or planned corrective action: The facility immediately posted the fire marshal's direct contact information in the fire alarm system out-of-service policy. Steps to prevent recurrence: Fire marshal contact information will be verified and updated quarterly by designated staff. During any fire alarm system outage, staff will be reminded to reference the posted fire marshal contact information. How the facility plans to monitor future performance to ensure solutions are sustained: Quarterly checks will be conducted to confirm the fire marshal contact information remains visible and current at required locations. Person responsible for compliance: Maintenance Director	09/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245497	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven Homes Of Maple Plain	4848 GATEWAY BLVD , MAPLE PLAIN, Minnesota, 55359

(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) COMPLETION DATE
K0346 SS = F	Continued from page 3 Findings include: On 07/24/2025 at 9:24 AM, it was revealed by review of available documentation that the fire alarm system out-of-service policy was incomplete and did not list the appropriate contact information. An interview with the Environmental Services Director verified this deficient finding at the time of discovery.	K0346		
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, available documentation review, and staff interview, the facility failed to inspect and maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 4.6.12, 9.7.5, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.4 and 4.7. These deficient findings could have a widespread impact on the residents within the facility. Findings include:On 07/24/2025 at 10:53, it was revealed by observation that the Soiled Utility Room in Maple had missing ceiling tiles delaying the activation	K0353	Brief description of corrective action or planned corrective action: All missing ceiling tiles in the Soiled Utility Rooms were replaced by 7/28/25, to restore the integrity of the fire-rated ceiling assembly. Steps to prevent recurrence: Maintenance staff will conduct weekly rounds to check for missing or displaced ceiling tiles in all areas with sprinkler coverage during daily general building check. Any missing or displaced tiles identified during rounds will be replaced or repositioned the same day. How the facility plans to monitor future performance to ensure solutions are sustained: The maintenance supervisor will review weekly round logs and visually verify ceiling tile integrity during daily general building walkthroughs. Person responsible for compliance: Maintenance Supervisor	09/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245497	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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Haven Homes Of Maple Plain	4848 GATEWAY BLVD , MAPLE PLAIN, Minnesota, 55359

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K0353 SS = F	Continued from page 4 time of automatic fire sprinkler.On 07/24/2025 at 11:01, it was revealed by observation that the Soiled Utility Room in Oak had missing ceiling tiles delaying the activation time of the automatic fire sprinkler.On 07/24/2025 at 11:12, it was revealed by observation that the Soiled Utility Room in Willow had missing ceiling tiles delaying the activation time of the automatic fire sprinkler. An interview with the Environmental Service Director verified these deficient findings at the time of discovery.	K0353		
K0354 SS = F	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24 hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire sprinkler out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, and 9.7.5, and NFPA 25 (2010 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 15.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 07/24/2025 at 9:25, it was revealed by review of available documentation that the sprinkler system out-of-service policy was incomplete and did not list the appropriate contact information. An interview with the Environmental Services Director verified this deficient finding at the time of	K0354	Brief description of corrective action or planned corrective action: The facility immediately posted the fire marshal's direct contact information in the fire alarm system out-of-service policy. Steps to prevent recurrence: Fire marshal contact information will be verified and updated quarterly by designated staff. During any fire alarm system outage, staff will be reminded to reference the posted fire marshal contact information. How the facility plans to monitor future performance to ensure solutions are sustained: Quarterly checks will be conducted to confirm the fire marshal contact information remains visible and current at required locations. Person responsible for compliance: Maintenance Director	09/05/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245497	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

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Haven Homes Of Maple Plain	4848 GATEWAY BLVD , MAPLE PLAIN, Minnesota, 55359

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K0354 SS = F	Continued from page 5 discovery.	K0354		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 20, 2025

Administrator
Haven Homes of Maple Plain
4848 Gateway Blvd
Maple Plain, MN 55359

RE: CCN: 245497
Cycle Start Date: July 24, 2025

Dear Administrator:

On September 11, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore, no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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