STATE LICENSING COMPLIANCE REPORT

Report #: HL207124112C

Date Concluded: June 4, 2025

Name, Address, and County of Facility Investigated:
Maplewood Assisted Living
1890 Sherren Avenue East
Maplewood, MN 55109
Ramsey County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Lissa Lin, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20712	A. BUILDING: _____ B. WING _____	C 05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD ASSISTED LIVING	1890 SHERREN AVENUE EAST MAPLEWOOD, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL207126258C/HL207128722M HL207125546C/HL207128503M HL207124112C On May 6, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 51 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for HL207125546C/HL207128503M, tag identification 2360. The following correction order is issued for HL207124112C, tag identification 880. No correction orders are issued for HL20712258C/HL207128722M.	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.	

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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 record review, observation and interviews, the licensee failed to keep 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. The facility had an on-going mouse and ant infestation in the building; the third floor memory care unit was particularly active. The memory care unit was dirty with debris, staining and odor. This had the potential to affect all residents, staff members, visitors and volunteers. 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, staff members and visitors. The findings include:	0 800		

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0 800	Continued From page 2 PEST CONTROL During a building tour on May 6, 2025 at 10:20 a.m., the investigator observed renovation construction on the first floor. Licensed assistant living director LALD-A, said the first and second floors were undergoing renovation first and the third floor memory care would be last. The decor and flooring were about 15 years old and showing its age, especially in memory care. On the memory care unit, the investigator observed areas of stained carpet in the TV gathering space. There was also the smell of garbage or spoilt food in the same area. Several residents and a staff member were watching TV. During an interview on May 6, 2025, at 11:25 a.m., unlicensed personnel (ULP)-C said the building had a mouse and ant infestation when she was hired back in January 2025. The infestation was especially bad in memory care where she was regularly scheduled. She found a dead mouse on a resident's bed recently and an "army" ant, the large black ants, in a resident's food bowl during a meal. ULP-C said a visiting hospice nurse reported she saw a mouse running along one memory care hallway recently. During an interview on May 6, 2025, at 1:00 p.m., ULP-D said there was only one housekeeping staff for the entire building. An activities staff person helped clean common areas a few days each week. She said the mice and ants were all over the building but worst on the third floor memory care unit. She was not sure how often pest control came to treat the building. ULP-D said the ongoing construction added to the mouse problem. Maintenance staff did not do any pest control. ULP-D said "The mice access the third floor from the registers. Everyone knows it's a problem." ULP-D stated the red stained areas	0 800		

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0 800	Continued From page 3 in the unit tried to be cleaned but were permanent. ULP-D said the ULP's are supposed to clean the dining room after meals but do not or clean very little. During an observation on May 6, 2025, at 1:00 p.m., the investigator observed on the third floor memory care unit the following: TV Room -AC (air conditioner)/heating register screens encrusted with dirt and food debris. -Red liquid stained on top of an AC/heating register and was splashed along the wall, baseboards and carpet. -Underneath the AC/heating register there was one rodent bait station, a plastic spoon and food debris. -Another register in the TV area also had food debris and dirt clogged screens. Dining Room -Odor, strongly smelled of garbage or spoilt food. -The floor was stained and sticky; the investigator's and ULP-D's shoes stuck to the floor. -Observed a dozen large black ants on the floor and walls in the dining room. -There was a dead black ant on the counter by the stove and a live black ant crawled the counter. -A mouse run behind the countertop toaster next to the stove, and then run behind the stove. -There was food debris and mouse feces behind the toaster. -Several empty drawers and cupboards contained mouse feces, food debris and dried stains. -One drawer stocked with paper placemats and napkins had mouse feces. During an interview on May 6, 2025, at 3:20 p.m., LALD-A said the facility used a pest control	0 800		

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0 800	Continued From page 4 company but did not recall when they were last out to service the building. LALD-A said they started weekly treatments last October after they were cited by the Minnesota Department of Health (MDH) surveyors, then went to bi-weekly, then monthly treatments as mouse problems improved. She said there were plans to install new mesh grates or screens over the AC units later this summer or fall. LALD-A said the third floor memory care dining room cupboards were not used for anything and mice and ants were more active in spring. Review of a Service Summary Report from the pest control, dated November 14, 2024, indicated licensee staff reported mice on third and second floors running from heat registers. Required licensee actions included hole in exterior wall and AC grate needs to be re-attached and hole in wall sealed. Review of a Service Summary Report from the pest control, dated November 20, 2024, indicated the technician reviewed with LALD-A and maintenance staff the concern that AC unit vents needed 1/4 inch screening to exclude rodents from the building. Review of a Service Summary Report from the pest control, dated December 10, 2024, indicated the technician spoke with maintenance staff about open AC grates on the lower level of building. Required licensee actions included hole in exterior wall and AC grate needs to be re-attached and hole in wall sealed. Review of a Service Summary Report from the pest control, dated January 7, 2025, indicated multiple reports of mice sightings. The technician indicated he found a lot of food and	0 800		

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0 800	Continued From page 5 wrappers/tissues, shoved inside heat registers in third floor common area, which would contribute to the amount of mice activity seen. Required licensee actions included cleaning as needed to remove food residue under appliances, machinery and equipment (third floor heat registers). Review of a Service Summary Report from the pest control, dated May 2, 2025, indicated maintenance staff and log book entries reported activity in third floor memory care TV room. The technician found large holes in corners of a heat register in memory care TV room. He also found many pieces of food on the TV room floor, including an almost full granola bar sitting on window sill. Recommended to nursing staff to clean food debris when found. STAINED CARPET AND WALLS During an observation on May 6, 2025, at 1:15, the investigator found birdseed spilled on the floor next to the aviary on third floor. During an observation on May 6, 2025, at 1:19 p.m., the investigator observed in room 301 a dark red irregular-shaped stain on the carpet by the bathroom door. A family member said the stain was blood left from when the resident fell a few days earlier. No staff had come to deep clean the the carpet and LALD-A was aware of the stain. On May 6, 2025, at 1:34 p.m., the investigator observed a thick, dark brown stain on the carpet by a memory care medication cart. During an interview on May 6, 2025 at 1:00 p.m., ULP-D said third floor cleaning was neglected. ULPs do not help clean stains or spills and they	0 800		

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0 800	Continued From page 6 were supposed to clean biohazard body fluids or feces stains, but they leave them for the housekeeper to clean. ULP-D said she had found dried feces stains. The housekeeping cleaning schedule was: Monday, clean first floor Tuesday, clean 1/2 of second floor Wednesday, clean other 1/2 of second floor Thursday, clean 1/2 of third floor Friday, clean other 1/2 of third floor. During an interview on May 6, 2025, at 1:00 p.m., activity staff (AS)-E said she cleans the common areas on Mondays and Wednesdays in addition to her resident activities job. She and the housekeeper have asked LALD-A to hire another housekeeper, even part-time, but that has not happened. During an interview on May 6, 2025, at 3:20 p.m., LALD-A said the sticky floor in the dining room maybe from cleaning chemicals and they are considering using other products. The ULPs were supposed to clean the dining rooms and any body fluid spills or stains, not housekeeping. Maintenance cleans deep spills. The stained carpet in room 301 would have been cleaned today, but the maintenance staff member had a pre-planned day off. LALD-A said the shampoo machine was large and loud so they would have to move the resident to a different room for a few hours and the family did not want that. The licensee's Mission Statement indicated they strive to put the residents, tenants and families first with the intent to fulfill the community's need for health and housing in comfortable, well-equipped, pleasant home-like surroundings.	0 800		

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0 800	Continued From page 7 The Employee Handbook, undated indicated staff were to keep their work area neat, clean and organized. Report anything needing repair or replacement to your supervisor. TIME PERIOD TO CORRECT: SEVEN (7) DAYS	0 800		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one resident(s) reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and an individual person was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360		