

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL207128503M
Compliance #: HL207125546C

Date Concluded: June 4, 2025

Name, Address, and County of Licensee

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

Finding: Substantiated, individual responsibility

Nature of Investigation:

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):

The AP financially exploited the resident when she used the resident's debit card to purchase Uber rides for herself.

Investigative Findings and Conclusion:

The Minnesota Department of Health determined financial exploitation was substantiated. The AP was responsible for the maltreatment. The AP found and used the resident's debit card information to purchase various goods and services for herself on multiple dates. The approximate total of purchases was \$9,900.00.

The investigator conducted interviews with facility staff members, including administrative staff and unlicensed staff. The investigator contacted law enforcement and the resident's family member. The investigation included review of the resident records, facility internal investigation, facility incident reports, personnel file, staff schedules, law enforcement report,

related facility policy and procedures. Also, the investigator observed the resident interacting with staff members.

The resident lived on the memory care floor of the facility. The resident's diagnoses included mild cognitive impairment and schizoaffective disorder. The resident's service plan included assistance with dressing, toileting, bathing, reassurance checks, medication administration and transfers. The resident was her own decision maker and had a trust that paid some of her bills. She also had a family member who was available to assist with finances as needed. The nurse assessed the resident as forgetful. She could follow through with simple tasks but not complex tasks. The resident did not have the reasoning or initiative for self-care, including finances, personal care and obtaining personal supplies. She needed daily reminders for routines.

According to law enforcement records, the facility staff contacted police the summer of 2024 with a concern of fraudulent purchases made with the resident's debit card. The resident received a bank statement and a staff member reviewed it with her to reconcile purchases. There were a number of purchases made with the resident's debit card for food delivery, Uber ride services and store purchases. The resident did not make those purchases. She had personal care staff from another company who took her out for coffee and to shop at a store, but those items and services were authorized purchases and not in question, according to law enforcement records.

Law enforcement records indicated the AP purchased Uber ride services with the resident's debit card. The AP purchased over 170 rides; most from her home to the facility and back to her home when she was done working. The cost was \$2,600.

Law enforcement records indicated there were numerous purchases made on food delivery service during 2023 to 2024. Some of the larger purchases ranged from \$200 to \$1,900 dollars from an online store. About \$2,800 were purchases from a store that started in 2023. The amounts of unauthorized purchases provided by law enforcement total about \$9,900.

The resident initially agreed to do an interview but then declined. She said she knew some of her money was gone and she probably would not get it back.

During an interview, the administrator said there had been a previous concern of possible financial exploitation of the resident involving a debit card and different staff member who no longer worked at the facility. After that incident, all staff, including the AP, were re-educated on vulnerable adults and financial exploitation. The administrator was surprised when law enforcement called her several months ago with new information on the resident's case that involved the AP and fraudulent purchases. The administrator started an internal investigation which included determining if the AP received rides to work from a ride service. Staff members she interviewed said someone drove the AP to and from work, but they did not know details. The administrator and law enforcement asked the AP to meet with them, but the AP did not show up for the meeting and did not return their calls. The AP is no longer employed at the

facility. The administrator said she notified the resident's family member about the financial exploitation and the debit card was stopped.

During an interview, the AP said she worked at the facility about one year and was a direct care provider for the resident. One day she found a card on the floor outside the resident's apartment door. She called it a credit card but was not sure and said it could have been a debit card. The AP copied the card information to purchase groceries and clothes at a store and various items online. She purchased Uber rides to and from work. She did not recall when she started using the card. She said she knew what she was doing was wrong when she used the resident's debit card, but she needed food and had house expenses. The AP said she was sorry. The AP said she did not meet with the administrator and law enforcement about the debit card because she was "busy" that day.

Review of the AP's personnel file included her job description, which included promoting the resident's right to be free from abuse, mistreatment, neglect or misappropriation of resident property. The AP would also maintain care and security of resident's personal possessions.

During an interview, the family member said the resident had a trust to pay for some of her monthly expenses. He was a financial representative for the resident, but did not have access to all her finances and account information so he was not aware of the financial exploitation until law enforcement and the facility staff called him with concerns. The debit card account was closed, and the fraudulent purchases have stopped. He now helped order items for the resident. The family member said overall the facility has been good communicating concerns to him.

The complainant did not return calls for an interview.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9

"Financial exploitation" means:

- (1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
 - (2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
- (b) In the absence of legal authority a person:
- (1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;

(2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;

Mitigating Factors considered, Minnesota Statutes, section 626.557, Subd. 9c(f):

(1) The AP did not follow an erroneous order, direction or care plan with awareness and failure to take action.

The facility did not direct an erroneous order, direction, or care plan.

(2) The facility was in compliance with regulatory standards.

The facility provided proper training and/or supervision of staff.

The facility provided adequate staffing levels.

(3) The AP failed to follow the facility directive and/or policies and procedures.

The AP failed to follow professional standards and/or exercise professional judgement.

The AP failed to act in good faith interest of the vulnerable adult.

The maltreatment was not a sudden or foreseen event.

Vulnerable Adult interviewed: Declined.

Family/Responsible Party interviewed: Yes.

Alleged Perpetrator interviewed: Yes.

Action taken by facility:

The facility completed an internal investigation and the AP is no longer employed by facility.

Action taken by the Minnesota Department of Health:

The facility was issued a correction order regarding the vulnerable adult's right to be free from maltreatment.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:

The Office of Ombudsman for Long Term Care

The Office of Ombudsman for Mental Health and Developmental Disabilities

Ramsey County Attorney

Maplewood City Attorney

Maplewood Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20712	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/06/2025
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NAME OF PROVIDER OR SUPPLIER MAPLEWOOD ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 1890 SHERREN AVENUE EAST MAPLEWOOD, MN 55109
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>HL207126258C/HL207128722M HL207125546C/HL207128503M HL207124112C</p> <p>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.</p> <p>The following correction order is issued for HL207125546C/HL207128503M, tag identification 2360.</p> <p>The following correction order is issued for HL207124112C, tag identification 880.</p> <p>No correction orders are issued for HL20712258C/HL207128722M.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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0 800 SS=F	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(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.</p> <p>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.</p> <p>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.</p> <p>The findings include:</p>	0 800		
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0 800	<p>Continued From page 2</p> <p>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.</p> <p>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.</p> <p>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</p>	0 800		

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0 800	<p>Continued From page 3</p> <p>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.</p> <p>During an observation on May 6, 2025, at 1:00 p.m., the investigator observed on the third floor memory care unit the following:</p> <p>TV Room</p> <ul style="list-style-type: none"> -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. <p>Dining Room</p> <ul style="list-style-type: none"> -Odor, strongly smelled of garbage or spoiled 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. <p>During an interview on May 6, 2025, at 3:20 p.m., LALD-A said the facility used a pest control</p>	0 800		

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0 800	<p>Continued From page 4</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	0 800		

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0 800	<p>Continued From page 5</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	0 800		

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0 800	<p>Continued From page 6</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	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		