

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL363689462M
Compliance #: HL363683720C

Date Concluded: April 13, 2026

Name, Address, and County of Licensee

Investigated:

Goodneighbors Maplewood Manor
1010 1st Street NE
Elbow Lake, MN 56531
Grant County

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

Evaluator's Name:

Jana Wegener, RN, Special Investigator

Finding: Substantiated, facility 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 facility neglected the resident when they failed to administer his Sinemet as ordered to treat Parkinson's for four days leading to a decline, falls, and likely bruising.

Investigative Findings and Conclusion: The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. The resident missed 4 days (11.5 doses) of Sinemet (a medication for Parkinson's disease) as ordered, then sustained a fall with a decline in condition requiring evaluation in the emergency department (ED). The ED record indicated the residents decline was caused by the resident not receiving Sinemet as ordered.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted the resident's family. The investigation included review of the resident record(s), ED/hospital records, pharmacy records, facility incident reports, personnel files, staff schedules, and related facility policy and

procedures. Also, the investigator observed the resident and medication administration practices at the facility.

The resident resided in an assisted living memory care unit with diagnoses including Parkinson's disease (a chronic neurodegenerative disorder that impairs movement and motor control) and dementia. The resident's assessment indicated the resident was cognitively impaired and required assistance with activities of daily living (ADL's) including dressing, grooming and incontinence care in the morning, with evening care, and as needed. The assessment indicated the resident alerted staff to toileting needs. The assessment indicated the resident received medication management and administration services. The resident had a history of falls, which at times resulted in bruising.

A concern arose when the facility did not administer the resident's Sinemet as ordered for four days. Additionally, concerns arose regarding incontinence cares and personal hygiene.

Regarding the resident's personal hygiene and incontinence cares, the resident's service delivery record indicated the resident received cares and services as indicated in his plan of care with no concerns of neglect with ADL's. Additionally, during onsite observation, the resident appeared clean and well-groomed with no indication of neglect with ADL's.

Medication Error

The resident's plan of care indicated the facility provided medication administration by trained medication passers. The plan of care indicated staff would report all late medications, out of stock medications, or declined medications to the nurse. The plan of care indicated staff members, and the nurse would monitor supplies and reorder as needed.

The resident's medication administration record (MAR) indicated the resident was prescribed Sinemet 50/200 mg tablets for Parkinson's disease, with instructions to take 2 tablets 4 times daily at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 10:00 p.m.

A review of the MAR indicated there were four consecutive days the facility did not administer the resident's Sinemet as ordered.

Day One

The MAR notes indicated the resident's supply was down to one tablet, when two were prescribed.

The progress notes indicated the unlicensed caregiver passing the medications contacted a nurse, who instructed her to give the half dose and document any missed doses as not given and the medication as not in the facility. The same document indicated the unlicensed caregiver had reordered the Sinemet.

Day Two

The MAR continued to reflect that the facility did not have the resident's Sinemet on hand to administer. While the morning doses were circled in red indicating the medications were not given, by the afternoon the MAR was grayed out [indicating the medication was held].

A review of the medical provider's orders identified there was no order for the medication to be held.

The progress notes indicated the facility re-ordered all of the resident's active medications.

A fax indicated the facility notified the provider they were out of the resident's Sinemet, then re-ordered it.

Day Three

The MAR indicated the facility did not administer Sinemet for the resident as ordered.

Day Four

The MAR indicated the facility did not administer Sinemet for the resident as ordered.

At 10:16 a.m., a progress note indicated the night shift had reported the resident had knocked over his lamp overnight. The same note indicated an unwitnessed fall may have occurred as the resident had a long bruise on the back of the resident's legs. Additionally, the resident "did not seem himself" and could be related to missed medications. The nurse directed a set of vital signs and neuro checks completed, which were within normal limits.

At 1:06 p.m., a progress note indicated the unlicensed caregivers continued to report the resident was not himself and was tearful. After a discussion with the power of attorney, the resident was sent to the ED.

A review of the MAR indicated the resident missed a total of 11.5 doses of Sinemet over these four days.

The resident's ED record following the incident indicated the resident had gone without his Sinemet for three days because the facility had run out of the medication. The ED record indicated one dose of Sinemet was given to the resident and then he was discharged back to the facility. The record indicated the resident's change in mental status and disorientation was due to the resident not receiving the Sinemet for several days.

The facility investigation documentation into the resident's Sinemet medication incident including staff interviews, findings, and actions taken to prevent recurrence including staff re-education on the medication re-ordering process and use of local pharmacy to fill critical medications in an emergency was requested, none was provided.

During an interview, facility leadership stated the resident's provider and pharmacy required 10-14 days to obtain a refill by mail. Leadership indicated staff had not notified nursing a refill was needed until the resident's medication had run out, then the medication was reordered. Leadership indicated critical medication like the resident's Sinemet should have been obtained from the local emergency pharmacy sooner. Leadership indicated staff should complete cart audits to look for medications that need refills and staff should notify nursing if the medication supply was getting low. When asked why the medication was not obtained through the emergency pharmacy sooner, leadership stated either staff did not understand what they should do, or they did not think of it.

One nurse stated prior to the incident staff looked for medications needing refills and observed the resident had half a bottle of Sinemet available but did not account for the fact the resident took 2 tablets 4 times per day and would run out. The nurse indicated the resident's refills required 14 days to obtain a refill from the pharmacy via mail and staff had not notified the nurse until the resident was out of the medication. The nurse indicated staff did not count the resident's Sinemet to identify a refill was needed and ensure he had enough medication available for staff to administer. The nurse verified there was no providers order to hold the resident's Sinemet and explained the medication was put on hold so staff would not call the on call nurse with each scheduled dose missed to report the medication was unavailable.

Another nurse stated staff should notify the nurse 10-14 days before a refill was needed for medications received via mail. The nurse indicated if a critical medication runs out, the medication should be obtained through the local emergency pharmacy, so the resident does not go without. The nurse stated the facility should have processes in place to ensure medications are re-ordered timely.

Unlicensed staff interviewed stated they would notify the nurse if a resident had 7 days of medication left and indicated there was no difference in the process for the resident's medications which had to be mailed.

When interviewed the resident's family member denied having concerns with the facility providing assistance with ADL needs and denied any concerns with bruising or abuse. The family member stated the resident ran out of Sinemet and went without for days which was unacceptable. The family stated the facility should have taken action to ensure the medication was available to administer and indicated missing the Sinemet as ordered caused the resident to suffer a decline in cognition, increased weakness, fatigue, restlessness, and confusion requiring evaluation and treatment in the ED.

In conclusion, the Minnesota Department of Health determined neglect 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.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17

“Neglect” means neglect by a caregiver or self-neglect.

(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is: (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and (2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes

Family/Responsible Party interviewed: Yes

Alleged Perpetrator interviewed: N/A

Action taken by facility: The facility faxed the resident’s provider for a refill after his Sinemet ran out, then 4 days later transferred the resident to the ED and obtained the resident’s medication from an emergency pharmacy.

Action taken by the Minnesota Department of Health: The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

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 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

Grant County Attorney

Grant City Attorney

Elbow Lake Police Department

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36368	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2026
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NAME OF PROVIDER OR SUPPLIER MAPLEWOOD MANOR LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1010 1ST STREET NE ELBOW LAKE, MN 56531
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0 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>HOME CARE PROVIDER/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>#HL363689462M/HL363683720C</p> <p>On February 13, 2026, 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 36 residents receiving services under the provider's Assisted Living with Dementia Care license.</p> <p>The following correction order is issued/orders are issued for #HL363689462M/HL363683720C, tag identification 1690, and 2630.</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>	
01690 SS=G	144G.71 Subdivision 1 Medication management services	01690		

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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01690	<p>Continued From page 1</p> <p>(a) This section applies only to assisted living facilities that provide medication management services.</p> <p>(b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.</p> <p>(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.</p> <p>This MN Requirement is not met as evidenced by: Based in interview and record reviewed, the licensee failed to ensure medications were administered as prescribed for one of one resident (R1) with records reviewed. The licensee failed to ensure medications were reordered</p>	01690		

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01690	<p>Continued From page 2</p> <p>timely and available for staff to administer as ordered. R1 was harmed when he missed 11.5 doses of Sinemet (a medication used to manage symptoms of Parkinson's disease) and suffered a decline in condition requiring evaluation in the emergency department (ED). This had the potential to affect all resident's receiving medication management services.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>Findings include:</p> <p>R1 was admitted to the licensee secure memory care unit on October 23, 2025, with diagnoses including Parkinson's disease, and dementia.</p> <p>R1's assessment and plan of care dated December 1, 2025, prior to the incident, indicated medications were to be administered as prescribed. The assessment and plan of care indicated late, out of stock, or declined medications should be reported to the Registered Nurse (RN) and followed up on 24 hours per day, 7 days per week. The assessment and plan of care indicated medications are set up by pharmacy per providers orders and verified by RN on arrival. The assessment and plan of care indicated the RN monitored medication supplies and reorders as needed, and staff would observe for low supplies and report to RN if in need of reorder.</p>	01690		
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01690	<p>Continued From page 3</p> <p>A pharmacy delivery slip dated January 5, 2026, for RX# 4708601A, Carbidopa 25 milligram (mg)/Levodopa 100 mg tablets Sinemet (a medication used to help manage symptoms associated with Parkinson's disease) was filled last on September 4, 2025, prior to R1's admission to the facility, and approximately 4 months prior to the incident. The delivery slip indicated R1 was provided a 60 day supply of the medication and indicated no other refills had been provided prior to the incident.</p> <p>R1 medication administration record (MAR) for January 2026, included orders for Carbidopa/L-Dopa (Sinemet) 50/200 mg tablets for Parkinson's disease, with instructions to take 2 tablets 4 times daily at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 10:00 p.m. The MAR had circled doses beginning on January 1, 2026, at 4:00 p.m. indicating the medication was not administered as ordered, with a total of 12 doses of the medication not administered over the next 4 days. Although the MAR indicated the medication was held during that time, the record lacked providers orders for R1's medication to be held. The MAR administration notes for why the medication was not given indicated staff documented only 1 pill remained, then the medication was out of stock and unable to be administered.</p> <p>On January 1, 2026, at 11:42 a.m. a nurse progress note indicated staff called the on-call nurse and reported only 1 tablet of Sinemet remained. Staff were instructed by the nurse to give a partial dose and document any missed doses as the medication was not available.</p> <p>On January 2, 2026, at 8:43 a.m. RN-E documented calling the provider and re-ordered all active medications and faxed the provider</p>	01690		
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01690	<p>Continued From page 4</p> <p>regarding missed medications.</p> <p>On January 2, 2026, at 3:39 p.m. after R1 had missed 3 doses of Sinemet, a faxed communication from RN-E to R1's provider indicated R1's Sinemet was out on order, and he had received the last available dose that morning. The communication failed to accurately report R1 had missed several doses of the medication due to being out of stock and unavailable.</p> <p>On January 4, 2026, at 1:03 p.m. after missing another 8 doses of Sinemet, a progress note indicated R1 was tearful, not himself, unable to express himself, and was transferred to the ED for altered mental status and fall.</p> <p>R1's record lacked any indication staff had communicated the medication needed to be reordered prior to it being out of stock.</p> <p>On February 11, 2026, approximately 1 month following the incident R1's progress notes indicated staff notified on-call nursing only 1 tablet of vitamin D3 was available to be administered. The note indicated staff were instructed to give a partial dose and the staff was educated to notify nursing of refill needs 10-14 days for medication refills to be mailed. The note indicated issues with obtaining the resident's medications timely to ensure they were available for staff to administer as ordered remained pervasive following the incident.</p> <p>R1's ED record dated January 4, 2026, indicated R1 had gone without his Sinemet for 3 days because the facility had run out of the medication. The ED record indicated one dose of Sinemet was given to R1 then he was discharged back to the facility. The record indicated R1's change in</p>	01690		

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01690	<p>Continued From page 5</p> <p>mental status and disorientation was due to him not receiving the Sinemet for several days.</p> <p>On February 13, 2026, at 12:00 p.m. operations supervisor (OS)-F stated R1 went the weekend without Sinemet as prescribed, and the issue should have been addressed sooner. OS-F stated RN-E was not aware or did not think to use the local emergency pharmacy to obtain R1's medications so he did not go without. OS-F indicated Assisted Living Director (ALD)-B and Assisted Director in Residence (ADR)-A had completed an investigation of the incident and provided staff re-education on the medication reordering process.</p> <p>On February 13, 2026, at 12:47 p.m. ALD-B stated R1's medication had run out and they only had 1 pill left. ALD-B stated he investigated the incident and found R1 had gone without his Parkinson's medication and indicated a provider should have been contacted to obtain a prescription for Sinemet through the emergency pharmacy sooner. ALD-B stated R1's provider and pharmacy required 10-14 days to obtain a refill by mail. ALD-B stated staff were re-educated on the process of reordering R1's medications timely and use of the emergency pharmacy.</p> <p>On February 13, 2026, at 10:30 a.m. ADR-A stated staff had not notified nursing a refill was needed until R1's medication had run out, then the medication was reordered. ADR-A stated she would expect staff to pay attention and re-order R1's medications when he has 7 days left. ADR-A was not aware R1's medications should be re-ordered 2 weeks prior to running out.</p> <p>On February 13, 2026, at 12:12 p.m. Unlicensed</p>	01690		
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01690	<p>Continued From page 6</p> <p>Personnel (ULP)-G stated all refills including medications that needed to be mailed should be reordered 7 days before running out. ULP-G was not aware R1's medications should be re-ordered 2 weeks prior to running out.</p> <p>On February 13, 2026, at 12:30 p.m. Unlicensed Personnel (ULP)-H stated all refills including medications that needed to be mailed should be reordered 7 days before running out. ULP-H was not aware R1's medications should be re-ordered 2 weeks prior to running out.</p> <p>On February 19, 2026, at 2:33 p.m. RN-I stated staff should complete cart audits to look for medications that need refills and staff should be notifying nursing if the medication supply was low at least 2 weeks prior to running out.</p> <p>On February 19, 2026, at 3:08 p.m. RN-J stated she was not aware of a policy or procedure for use of the emergency pharmacy to obtain critical medications. RN-J indicated R1's medications were mailed and took longer to receive and needed to be re-ordered timely to prevent running out. RN-J stated a order for an emergency fill should have been obtained from the local pharmacy to prevent R1 from going without the medication.</p> <p>On February 19, 2026, at 4:00 p.m. RN-E stated staff had looked for medications that needed refills and observed R1 had half a bottle of Sinemet available but did not account for the fact the resident took 2 tablets 4 times per day and would run out. RN-E indicated R1's refills required 14 days to obtain a refill from the pharmacy via mail and staff had not notified the nurse until R1 was out of the medication. RN-E indicated staff did not count R1's Sinemet to identify a refill was</p>	01690		
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01690	<p>Continued From page 7</p> <p>needed and ensure he had enough medication available for staff to administer. RN-E verified there was no providers order to hold R1's Sinemet and explained the medication was put on hold so staff would not call the on call nurse with each scheduled dose missed to report the medication was unavailable to administer.</p> <p>On February 19, 2026, at 1:05 p.m. family member (FM)-C stated R1 ran out of Sinemet and went without for days which was unacceptable. FM-C stated the facility should have taken action to ensure the medication was available to be administered and indicated missing the Sinemet as ordered caused R1 to suffer a decline in cognition, increased weakness, fatigue, restlessness, and confusion.</p> <p>The licensee investigation documentation into R1's Sinemet medication omission incident including staff interviews, findings, and actions taken to prevent recurrence including staff re-education on the medication re-ordering process and use of emergency pharmacy for critical medications was requested, none was provided. Staff at the facility interviewed lacked knowledge and understanding that R1's medication needed to be re-ordering via phone or fax 2 weeks prior to running out as a result there was no indication the facility to action to prevent the incident from recurring including providing re-education on reordering for medications to be mailed and use of the emergency pharmacy.</p> <p>The licensee incident reports were reviewed and lacked any documentation/reports of errors in omission from the time of the incident.</p> <p>A licensee policy and procedure titled "Medication & Supplies - Reordering" dated August 1, 2021,</p>	01690		

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(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
01690	<p>Continued From page 8</p> <p>indicated community staff would make sure medications and supplies are ordered and available as needed. If a resident needs medication(s) and/or supplies reordered from the pharmacy or supplier, staff will contact the pharmacy or supplier by faxing the prescription refill or request. Verification of sent fax will be kept with the reorder sheet in the community pharmacy communication book for thirty (30) days. Daily, medications will be reordered by sending notification (i.e. faxing) to the designated pharmacy or supplier. Prior to holidays, weekends, etc. the RN, LPN or designated staff member(s) will plan for needs of residents for refills on prescriptions. When pharmacy is unable to refill a prescription(s) for any particular reason; this is communicated to the nursing staff immediately. Nursing staff will inform the resident primary care provider, either by phone or fax, and make a nursing note entry into the resident When residents use a mail order pharmacy program, staff will notify family if the resident has less than two (2) weeks of medication remaining.</p> <p>A licensee policy and procedure titled "Medication Error" dated August 1, 2021, indicated whenever a medication error occurs, the person responsible for the error or the person who caught the medication error will contact a licensed nurse and explain the situation in detail with the medication name, dosage and amount given as well as the Resident involved. The licensed nurse will instruct the staff person on what to do next. This may include contacting the prescriber, family and/or 911. If the staff on duty is unable to have timely two-way communication with a licensed nurse, the staff person will immediately contact the prescriber and explain in detail the medication given, the dosage and amount. The staff person will document exactly what the prescriber stated</p>	01690		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36368	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/13/2026
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01690	<p>Continued From page 9</p> <p>and any orders and then will carry out the orders. The staff person involved will then complete a medication error report and document in the resident record progress notes what occurred (i.e., name of medication given), date and time, who was contacted and what the actions were to correct the situation.</p> <p>A licensee policy and procedure for implementing the local emergency pharmacy was requested, none was provided.</p> <p>No additional information was provided.</p> <p>TIME PERIOD TO CORRECT: Seven (7) days.</p>	01690		
02360	<p>144G.91 Subd. 8 Freedom from maltreatment</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment.</p> <p>Findings include:</p> <p>The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.</p>	02360		