Electronically Delivered

April 16, 2026

Licensee
Maplewood Homes of Faribault
519 1st Street Southwest
Faribault, MN 55021

RE: Project Number(s) SL37579016

Dear Licensee:

On April 3, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on June 26, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

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Electronically Delivered

April 2, 2026

Licensee
Maplewood Homes of Faribault
519 1st Street Southwest
Faribault, MN 55021

RE: Project Number(s) SL37579016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 26, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

pursuant to this survey:

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1.000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37579	A. BUILDING: _____ B. WING _____	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD HOMES OF FARIBAULT	519 1ST STREET SOUTHWEST FARIBAULT, MN 55021

(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 LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37579016-0 On June 23, 2025, through June 26, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were seven residents; seven receiving services under the Assisted Living Facility license. 1290: An immediate correction order was issued on June 23, 2025, at a level 3/Widespread (I). The licensee took immediate action, but the scope and level remains at I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 1 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screen for one of two employees (unlicensed personnel (ULP)-F). This had the potential to affect all current residents living in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 potential to affect a large portion or all of the residents).	0 660		

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0 660	Continued From page 2 The findings include: The licensee's TB facility risk assessment dated November 20, 2024, indicated the licensee was a low risk. ULP-F was hired on November 19, 2024, to provide direct care services for the licensee. ULP-F's employee file lacked evidence of a TB symptom screen. On June 25, 2025, at 10:19 a.m., licensed assisted living director (LALD)-A reviewed ULP-F's employee file and could not find evidence of a TB symptom screen. LALD-A stated she would check with Rice County Public Health to see if they had completed a TB symptom screen for ULP-F as they were contracted to complete all employees' TB testing requirements. The licensee's 8.16 Tuberculosis Screening policy dated June 2021, indicated: Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened & tested at the Rice County Public Health office for active signs of TB. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an	0 660		

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0 660	Continued From page 3 employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based	01290		

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01290	Continued From page 4 system for submitting background study requests to the Department of Human Services (DHS)) with the assisted living license for one of three employees (unlicensed personnel (ULP)-C). This had the potential to affect all residents residing in the facility. This resulted in an immediate correction order issued on June 23, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-C was hired on July 10, 2017, to provide direct care services for the licensee's residents. On June 23, 2025, at approximately 1:15 p.m., licensed assisted living director (LALD)-A provided the NETStudy 2.0 employee roster for health facility identification number (HFID) 37579 at the surveyor's request. ULP-C's background study dated October 27, 2021, was affiliated to HFID 37579, but indicated "Eligible - COVID-19 Study - Expired" with an expiration date of December 31, 2022, on the NETStudy 2.0 roster page. On June 23, 2025, at 2:34 p.m., LALD-A reviewed the NETStudy 2.0 employee roster and also reviewed ULP-C's information online in NETStudy 2.0. LALD-A was unable to find evidence ULP-C had been fingerprinted. LALD-A was not aware ULP-C's background study was COVID-19	01290		

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01290	Continued From page 5 NETStudy 2.0 expired and stated all employees were required to have a cleared background check before performing duties at the facility. LALD-A further stated ULP-C worked independently providing direct care to the residents. The Minnesota Department of Human Services website updated July 31, 2024, indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid and modifications ended January 1, 2023. Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated: No employee may provide direct services and have independent direct contact with any residents until acceptable result of the background study have been received.	01290		

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01290	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On June 23, 2025, the licensee took immediate action; however, the scope and level remains at I.	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01470		

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01470	Continued From page 7 other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one new unlicensed personnel (ULP-F) received orientation to assisted living facility licensing requirements and regulations before providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01470		

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01470	Continued From page 8 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 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). The findings include: ULP-F was hired on November 19, 2024, to provide direct care services for the licensee. ULP-F's employee records lacked evidence of receiving orientation to assisted living to include the following required content: - overview of assisted living statutes; - handling emergencies and using emergency services; - handling of resident complaints, reporting of complaints, where to report; - consumer advocacy services; and - orientation to each specific resident and services provided. On June 25, 2025, at 10:19 a.m., licensed assisted living director (LALD)-A stated she was unable to locate evidence the above trainings had been completed prior to providing services. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2021 indicated: 1. All [licensee name] employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. No further information was provided.	01470		

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01470	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included	01650		

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01650	Continued From page 10 all the required content for two of two residents (R1, R2). 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 potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnoses included bipolar disorder. R1's Individual Service Plan dated February 27, 2025, indicated R1 received services including medication administration and behavior monitoring. R2 R2's diagnoses included schizoaffective disorder and type II diabetes. R2's Individual Service Plan dated October 24, 2024, indicated R2 received services including medication administration, blood sugar monitoring, laundry, and behavior monitoring. R1 and R2's individual service plans lacked the following: - the schedule and methods of monitoring staff providing services On June 23, 2025, at 3:18 p.m., licensed assisted living director (LALD)-A reviewed R2's individual	01650		

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01650	Continued From page 11 service plan and stated it did not include the above required information. LALD-A further stated all residents utilized the same service plan format. The licensee's 6.08 Service Plan policy dated August 1, 2021, indicated: 9. A service plan will include: f. A schedule and method for the next planned monitoring of staff providing services No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of one resident (R2). This practice resulted in a level two violation (a	01710		

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	37579	A. BUILDING: _____ B. WING _____	06/26/2025

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MAPLEWOOD HOMES OF FARIBAULT	519 1ST STREET SOUTHWEST FARIBAULT, MN 55021

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01710	Continued From page 12 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 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). The findings include: During the entrance conference on June 23, 2025, at 11:05 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the residents at the facility. R2's diagnoses included schizoaffective disorder and type II diabetes. R2's Individual Service Plan dated October 24, 2024, indicated R2 received services including medication administration, blood sugar monitoring, laundry, and behavior monitoring. R2's provider note dated May 5, 2025, included a new order for Ozempic (used to manage type 2 diabetes or to reduce the risk of future cardiovascular events in people with type 2 diabetes) 0.5 mg (milligrams) once weekly with plans to continue to assess further dose increases. R2's medication administration record (MAR) dated June 2025, included: Ozempic 0.5 mg/2 ml (milliliters) subq (subcutaneously) weekly (Wednesdays). R2's annual Uniform Assessment Tool assessment dated November 8, 2024, indicated:	01710		

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01710	Continued From page 13 Resident is deemed ABLE to PARTIALL [sic] safely self-administer medications (describe): [R2] is able to apply creams and shampoo herself with the direction of the staff. On June 24, 2025, at 12:40 p.m., R2 stated she received her Ozempic injectable once a week. R2 stated office coordinator (OC)-H showed her how to set-up and administer the Ozempic and now she does it all on her own with staff supervision. R2's record did not include an assessment by the RN for R2's ability to self-administer the Ozempic. On June 25, 2025, at 12:08 p.m., clinical nurse supervisor (CNS)-B stated she had instructed R2 on how to administer the Ozempic independently and then observed R2 setting up the medication and injecting it. CNS-B stated she did not document assessment of R2's ability to self administer her Ozempic nor did she add it to R2's medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The	01730		

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01730	Continued From page 14 facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01730		

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01730	Continued From page 15 licensee failed to develop an individualized medication management plan with the required content for one of two residents (R2). 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 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). The findings include: During the entrance conference on June 23, 2025, at 11:05 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to the residents at the facility. R2's diagnoses included schizoaffective disorder and type II diabetes. R2's Individual Service Plan dated October 24, 2024, indicated R2 received services including medication administration, blood sugar monitoring, laundry, and behavior monitoring. R2's provider note dated May 5, 2025, included a new order for Ozempic (used to manage type 2 diabetes or to reduce the risk of future cardiovascular events in people with type 2 diabetes) 0.5 mg (milligrams) once weekly with plans to continue to assess further dose increases. R2's medication administration record (MAR) dated June 2025, included: Ozempic 0.5 mg/2 ml	01730		

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01730	Continued From page 16 (milliliters) subq (subcutaneously) weekly (Wednesdays). R2's annual Uniform Assessment Tool assessment dated November 8, 2024, indicated: Resident is deemed ABLE to PARTIALL [sic] safely self-administer medications (describe): [R2] is able to apply creams and shampoo herself with the direction of the staff. On June 24, 2025, at 12:40 p.m., R2 stated she received her Ozempic injectable once a week. R2 stated office coordinator (OC)-H showed her how to set-up and administer the Ozempic and now she does it all on her own with staff supervision. R2's Individualized Medication Medication Management Plan dated November 8, 2024, indicated R2 has diabetes and takes her own blood sugar tid (three times a day) with the ULP (unlicensed personnel) monitoring her; she also has a shampoo that she uses 1x/week (one time a week) PRN (as needed) that she uses on her own. The staff will give her the shampoo when it needs to be used and she does it independently in the shower. R2's medication management plan did not include R2's ability to self administer the Ozempic with staff supervision. On June 25, 2025, at 12:08 p.m., clinical nurse supervisor (CNS)-B stated she had instructed R2 on how to administer the Ozempic independently and then observed R2 setting up the medication and injecting it. CNS-B stated she did not document assessment of R2's ability to self administer her Ozempic nor did she add it to R2's medication management plan. No further information was provided.	01730		

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01730	Continued From page 17 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) documented resident-specific instructions for as needed (PRN) standing order medications for two of two residents (R1, R2) whose medication administration was delegated to unlicensed personnel (ULP). 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 potential to affect a large portion or all of the residents).	01750		

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01750	Continued From page 18 The findings include: R1 R1's diagnoses included bipolar disorder. R1's Individual Service Plan dated February 27, 2025, indicated R1 received services including medication administration and behavior monitoring. R2 R2's diagnoses included schizoaffective disorder and type II diabetes. R2's Individual Service Plan dated October 24, 2024, indicated R2 received services including medication administration, blood sugar monitoring, laundry, and behavior monitoring. R1's Physicians Standing Order list dated March 5, 2025, and August 19, 2024, respectively, each included the following orders: - Tylenol 500 mg (milligrams) 1-2 caps (capsules) PO (by mouth) Q (every) 4-6 hrs (hours) PRN pain, fever - MOM (milk of magnesia) 15-30 cc (cubic centimeters) PO QD (every day) PRN constipation - Benadryl 25 mg 1-2 caps PO Q 4-6 hrs PRN rhinitis/allergy symptoms - ibuprofen 200 mg 1-2 tabs PO Q 4-6 hrs PRN pain, fever - Icy Hot cream, apply thin layer to affected area PRN pain relief - Triple Antibiotic Ointment PRN to skin abrasions, lesions R1 and R2's record did not include specific	01750		

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01750	Continued From page 19 directions to staff on when to administer one or two tablets of the Tylenol, ibuprofen, and Benadryl; when to administer 15 or 30 cc's of MOM; and how often the Icy Hot cream and Triple Antibiotic Ointment could be administered. On June 24, 2025, at 12:32 p.m., ULP-E stated when administering Tylenol or ibuprofen from resident standing orders she would always give two tablets versus one because, "That's what I would take". ULP-E stated some of the PRN standing orders weren't specific on how much to give and would go with the higher amount unless the resident requested less. On June 25, 2025, at 12:08 p.m., clinical nurse supervisor (CNS)-B stated the identified standing orders did not give clear direction on what dosage to give the resident, and the identified topical medication ordered PRN only, did not include how often the medication could be administered. CNS-B further stated the same physician standing orders were utilized by all residents in the residence. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility.	02290		

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02290	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the rights of two of two residents (R1, R2) when the licensee required the resident or their representative to sign the House Rules form. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on June 23, 2025, at 11:48 a.m., licensed assisted living director (LALD)-A, the surveyor observed snacks were stored in a locked cabinet in the kitchen area. The sign on the cabinet indicated "Resident" snacks were served at 2:00 p.m. and "House" snacks were served at 7:00 p.m. R1 R1's diagnoses included bipolar disorder. R1's Individual Service Plan dated February 27, 2025, indicated R1 received services including medication administration and behavior monitoring. R2 R2's diagnoses included schizoaffective disorder and type II diabetes. R2's Individual Service Plan dated October 24,	02290		

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02290	Continued From page 21 2024, indicated R2 received services including medication administration, blood sugar monitoring, laundry, and behavior monitoring. R1 and R2's record each included a document titled, "House Rules". R1 signed the document on February 26, 2025, and R2 signed the document on October 12, 2009. The House Rules document contained the following verbiage: Exceptions to these rules must be specified within your Individual Service Plan. 2. Policy on drugs, alcohol and sexual activity. a) No street drugs or over the counter substance abuse. b) No alcohol consumption, unless you are on an approved outing and will not be returning to the facility after drinking. c) No marijuana is allowed on the premises regardless of the newly passed law. 3. No sexual relationships. (This means no dating the people you are living a. with, or any other sexual contact within the establishment) 4. No going to the bar, unless you have prior approval from your social worker or manager of the facility. You may only go to a bar for a social event. We don not want our residents "handing out" in the bars. 6. Snack Time a) Personal snack is at 2:00 p.m. b) House snack is at 7:00 p.m. c) No snacks, food, or drinks are allowed in bedrooms. Everything must be locked in the snack cabinet. Water is okay in bedrooms. 8. Phone usage b) No phone calls coming in or going out after 10:00 p.m. c) Fifteen (15) minute time limit on client phone. 11. Leaving and returning from the house.	02290		

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02290	Continued From page 22 a) All clients need to be in the house no later than 10:00 p.m. Sunday -Thursday & midnight on Friday and Saturday, unless you are on a schedule to leave. 13. Bedtime a) Sunday through Thursday: 10:00 p.m. is quiet time. Everyone will be in bed by 11:00 p.m. b) You may watch TV later in your room, not on the main floor, as long as you are not disturbing your roommates. c) Friday and Saturday clients may stay up until midnight. 14. Company a) You must have prior permission before having guests. b) All guest stays on the main floor. No guests are allowed in bedrooms. They need to remain in the common areas. c) All guests should be gone by 7 p.m. unless other arrangements have with management have been approved. d) Overnight guests are not allowed 15. Curfew a) All clients need to be in the house no later than 10:00 p.m. Sunday-Thursday & midnight on Friday and Saturday, unless you are on a schedule to leave. 16. Overnights a. All overnights need to have prior approval from Owner/Director by 3:00 p.m. b. Staff needs at least four hours' notice to pack medications. 17. Up Time a. All clients will be out of bed no later than 8:30 a.m., to receive their AM medications and eat breakfast. b. We will work with all medical issues. On June 24, 2025, at 9:12 a.m., unlicensed personnel (ULP)-E stated during the 2:00 p.m.	02290		

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02290	Continued From page 23 snack time, each resident could pick a snack from their personal snacks they had purchased; the 7:00 p.m. snack was provided by the licensee. ULP-E stated staff usually stick to these times as it's in the house rules; although if a resident is hungry and wants one of their own snacks, she will give it to them. ULP-E stated if they don't lock the snacks up, residents will help themselves to other residents' snacks. On June 24, 2025, at 9:47 a.m., LALD-A stated all residents are required to sign the house rules form when signing their initial contract. Many of the house rules were for the residents health and safety. Related to food - residents will help themselves to food that is not always appropriate. LALD-A stated one time a resident took a whole jar of peanut butter into his room and was eating it with a spoon. Another resident took raw meat out of the freezer into her room to eat. They keep the residents' snacks locked up except at 2:00 p.m. during snack time then monitor to make sure residents don't take from someone else. All food is pretty much locked up at night; although the refrigerator/freezer and cupboards are unlocked during the day. Related to bedtime, LALD-A stated many of the residents would stay up all night if they could, and then they don't get up for their medications, which is on the staff. LALD-A stated they also have restrictions on visitors. LALD-A further stated the rights restrictions were not included on the residents' service plans. MN Statute 144G.91 Subd. 9. Right to come and go freely indicated residents have the right to enter and leave the facility as they choose. This right may be restricted only as allowed by other law and consistent with the resident's service plan.	02290		

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02290	Continued From page 24 MN Statute 144G.91 Subd. 12. Visitors and social participation indicated residents have the right to meet with or receive visits at any time by the resident's family, guardian, conservator, health care agent, attorney, advocate, or religious or social work counselor, or any other person of the resident's choosing. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. MN Statute 144G.91 Subd. 18. Right to access food indicated residents have the right to access food at any time. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed for one of two residents	02320		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD HOMES OF FARIBAULT	519 1ST STREET SOUTHWEST FARIBAULT, MN 55021

(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
02320	Continued From page 25 (R4) observed during medication administration. 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 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). The findings include: R4's diagnoses included bipolar disorder and anxiety. R4's Individual Service Plan dated April 24, 2025, indicated R4 received services including medication administration. R4's provider visit note dated December 12, 2024, included the following orders: - citalopram 40 mg (milligrams) by mouth daily in the AM. - gemfibrozil 600 mg by mouth twice a day R4's annual Uniform Assessment Tool assessment dated April 24, 2025, indicated: Resident is deemed ABLE to PARTIALL [sic] safely self-administer medications (describe): [R4] is able to self-administer her inhaler when needed. On June 24, 2025, at 8:12 a.m., the surveyor observed unlicensed personnel (ULP)-E prepare the above scheduled morning medications for R4. ULP-E placed the medications into a medication cup then handed the cup to R4. R4 walked over to the refrigerator still holding the medication cup	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37579	A. BUILDING: _____ B. WING _____	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD HOMES OF FARIBAULT	519 1ST STREET SOUTHWEST FARIBAULT, MN 55021

(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
02320	Continued From page 26 with the medications, obtained a drink from the refrigerator, then walked into the dining room. ULP-E did not follow R4 into the dining and observe her consuming the medications. When interviewed immediately following the observation, ULP-E stated she wasn't worried about R4 taking the medication as it hadn't been a problem. ULP-E further stated there is only one resident (R6) in the house they watch carefully to ensure they swallow all medications upon administration. On June 25, 2025, at 12:08 p.m., clinical nurse supervisor (CNS)-B stated staff were trained, and expected, to remain with the resident when administering medications until all medications had been consumed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02460 SS=F	144G.91 Subd. 18 Right to access food Residents have the right to access food at any time. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure residents had access to food at any time for residents. This had the potential to affect all residents.	02460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37579	A. BUILDING: _____ B. WING _____	06/26/2025

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MAPLEWOOD HOMES OF FARIBAULT	519 1ST STREET SOUTHWEST FARIBAULT, MN 55021

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02460	Continued From page 27 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on June 23, 2025, at 11:48 a.m. with licensed assisted living director (LALD)-A, the surveyor observed snacks were stored in a locked cabinet in the kitchen area. The sign on the cabinet indicated "Resident" snacks were served at 2:00 p.m. and "House" snacks were served at 7:00 p.m. R1 R1's diagnoses included bipolar disorder. R1's Individual Service Plan dated February 27, 2025, indicated R1 received services including medication administration and behavior monitoring. R2 R2's diagnoses included schizoaffective disorder and type II diabetes. R2's Individual Service Plan dated October 24, 2024, indicated R2 received services including medication administration, blood sugar monitoring, laundry, and behavior monitoring. R1 and R2's record each included a document titled, "House Rules". R1 signed the document on February 26, 2025, and R2 signed the	02460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37579	A. BUILDING: _____ B. WING _____	06/26/2025

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MAPLEWOOD HOMES OF FARIBAULT	519 1ST STREET SOUTHWEST FARIBAULT, MN 55021

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02460	Continued From page 28 document on October 12, 2009. The current House Rules document contained the following verbiage: Exceptions to these rules must be specified within your Individual Service Plan. 6. Snack Time a) Personal snack is at 2:00 p.m. b) House snack is at 7:00 p.m. c) No snacks, food, or drinks are allowed in bedrooms. Everything must be locked in the snack cabinet. Water is okay in bedrooms. R1 and R2's record lacked documentation from a medical provider that R1 and R2 should be restricted from accessing foods or liquids. On June 24, 2025, at 9:12 a.m., unlicensed personnel (ULP)-E stated during the 2:00 p.m. snack time, each resident could pick a snack from their personal snacks they had purchased; the 7:00 p.m. snack was provided by the licensee. ULP-E stated staff usually stick to these times as it's in the house rules, although if a resident is hungry and wants one of their own snacks, she will give it to them. ULP-E stated if they don't lock the snacks up residents will help themselves to other residents' snacks. On June 24, 2025, at 9:47 a.m., LALD-A stated all residents are required to sign the house rules form when signing their initial contract. Many of the house rules were for the residents health and safety. Related to food - residents will help themselves to food that is not always appropriate. LALD-A stated one time a resident took a whole jar of peanut butter into his room and was eating it with a spoon. Another resident took raw meat out of the freezer into her room to eat. They keep the residents' snacks locked up, except at 2:00 p.m. during snack time, and then they monitor to	02460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37579	A. BUILDING: _____ B. WING _____	06/26/2025

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02460	Continued From page 29 make sure residents don't take from someone else. All food is pretty much locked up at night; although the refrigerator/freezer and cupboards are unlocked during the day. LALD-A further stated the rights restrictions were not included on the resident's service plans. On June 24, 2025, at 12:40 p.m., R2 stated staff put the lock on the snack cabinet about 8 years ago because some residents would take other residents' snacks. R2 further stated sometimes if you wanted a snack at a different time, you could ask staff and they would usually give it to you. MN Statute 144G.91 Subd. 18. Right to access food indicated residents have the right to access food at any time. This right may be restricted in certain circumstances if necessary for the resident's health and safety and if documented in the resident's service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02460		

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Maplewood Homes of Faribault
519 1st Street SW
Faribault, MN 55021
Rice County
Parcel:

Phone:

License Info

License: HFID 37579

Risk:
License:
Expires on:
CFPM: Esther E. Tabor
CFPM #: 89622; Exp: 6/22/2026

Inspection Info

Report Number: F7990251010
Inspection Type: Full - Single
Date: 6/26/2025 Time: 10:49:11 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

WE DISCUSSED EMPLOYEE ILLNESS, NOROVIRUS PREVENTION, AND HANDWASHING. AN EMPLOYEE ILLNESS LOG WAS ONSITE.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Mankato District Office inspection report number F7990251010 from 6/26/2025

Benjamin D. Ische

Esther Tabor
Manager

Ben Ische,
Public Health Sanitarian Supervisor
507-344-2710
ben.ische@state.mn.us

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Temperature Observations/Recordings

Establishment Info

Maplewood Homes of Faribault
Faribault
County/Group: Rice County

Inspection Info

Report Number: F7990251010
Inspection Type: Full
Date: 6/26/2025
Time: 10:49:11 AM

Equipment Temperature: Product/Item/Unit: Norlake Reach In**; Temperature Process:** Ambient Air
Location: Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Sanitizer Observations/Recordings

Establishment Info

Maplewood Homes of Faribault
Faribault
County/Group: Rice County

Inspection Info

Report Number: F7990251010
Inspection Type: Full
Date: 6/26/2025
Time: 10:49:11 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 400 PPM
Comment:
Violation Issued?: No