



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 13, 2026

Licensee

Maple Woods Assisted Living

33310 State Highway 6

Deer River, MN 56636

RE: Project Number(s) SL33975016

Dear Licensee:

On April 8, 2026, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 14, 2026. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 14, 2026 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 14, 2026, found not corrected at the time of the April 8, 2026, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a)

The details of the violations noted at the time of this follow-up survey completed on April 8, 2026 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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.

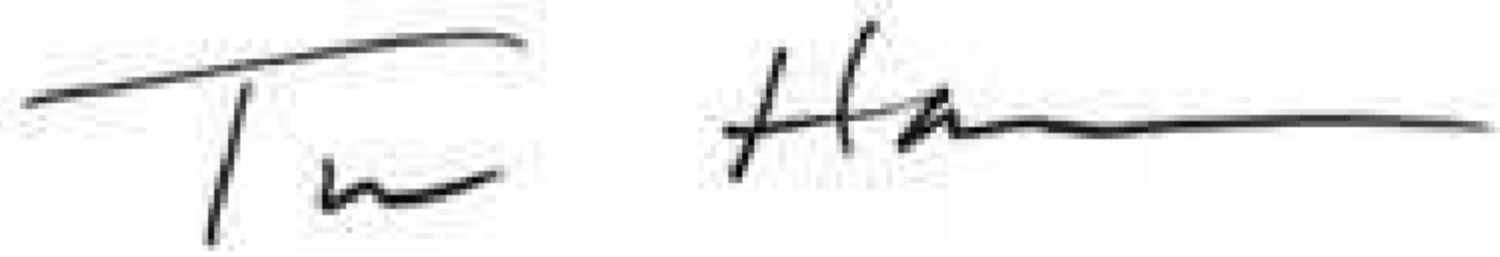
To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

We urge you to review these orders carefully. If you have questions, please contact Tim Hanna at 507-208-8982.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Tim Hanna", with a long horizontal flourish extending to the right.

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/08/2026
NAME OF PROVIDER OR SUPPLIER MAPLE WOODS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 33310 STATE HIGHWAY 6 DEER RIVER, MN 56636		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL33975019-1 On April 7, 2026, the Minnesota Department of Health conducted a follow-up survey for the above provider to follow-up on orders issued pursuant to a survey completed on January 14, 2026. As a result of the follow-up survey, the following orders were issued and/or reissued.	{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.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	{0 480}			

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 480}			
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 510}			

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{0 630}	Continued From page 3	{0 630}			
{0 630} SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 630}			
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement	{0 650}			

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{0 650}	Continued From page 4 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 650}			
{0 660} SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (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: Not reviewed during this survey.	{0 660}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	{0 680}			

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{0 680}	Continued From page 5 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 680}			
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	{0 775}			

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{0 775}	Continued From page 6 Level 2 Widespread F Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 7, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	{0 775}			
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse,	{01380}			

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{01380}	Continued From page 7 and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01380}			
{01440} SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.	{01440}			

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{01440}	Continued From page 8 This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01440}			
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01640}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the	{01760}			

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{01760}	Continued From page 9 resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01760}			
{01890} SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01890}			
{01910} SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been	{01910}			

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{01910}	Continued From page 10 discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01910}			
{02310} SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{02310}			
{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	{02320}			

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{02320}	Continued From page 11 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: Not reviewed during this survey.	{02320}			

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: 33975-016-01	Date: 4/7/2026
Facility Name: Maple Woods Assisted Living	
Facility Address: 33310 State Highway 6 Deer River, MN 56636	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread TIME PERIOD OF CORRECTION: Choose an item.

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Initiation of the fire alarm system in I-1 occupancies shall be by manual and automatic means. Approved automatic fire detectors shall be installed in laundry and soiled linen rooms, boiler and furnace rooms, mechanical and electrical rooms, shops, laboratories, kitchens, locker rooms, custodial closets, trash-collection rooms, storage rooms, lounges, gift shops, and similar areas. Automatic smoke detectors shall be provided in corridors and areas that are open to corridors.

Initiation of the fire alarm system in I-2 occupancies shall be by manual and automatic means. Approved automatic fire detectors shall be installed in laundry and soiled linen rooms, boiler and furnace rooms, mechanical and electrical rooms, shops, laboratories, kitchens, locker rooms, custodial closets, trash-collection rooms, storage rooms, lounges, gift shops, and similar areas. Hospitals, nursing homes (both intermediate care and skilled nursing facilities), board and care homes, and detoxification facilities shall be provided with smoke detection throughout the corridor and areas open to the corridors, other than nurses’ stations. [Minn. Stat. 144G.45 subd. 2; MSFC 907.2.6.1.1; 907.2.6.2.1]

Comments: There was not a fire alarm system present in the building with smoke detection in the areas required by the Minnesota State Fire Code for I-1 or I-2 facilities, as this facility is designated. The smoke/CO detectors will be installed this week or next.

3. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: No carbon monoxide protection was provided for the facility. They will be installed this week or next.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 19, 2026

Licensee

Maple Woods Assisted Living

33310 State Highway 6

Deer River, MN 56636

RE: Project Number(s) SL33975016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a SL33975016 on January 14, 2026, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

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/Bm5uQEpHVva>. 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,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER MAPLE WOODS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 33310 STATE HIGHWAY 6 DEER RIVER, MN 56636			
(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: SL33975016-0 On January 12, 2026, through January 14, 2026, 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 23 residents; 23 receiving services under the Assisted Living Facility with Dementia Care license.	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.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 12, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 3	0 480			
0 510 SS=F	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.. 144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during resident cares and medication administration for three of five employees (unlicensed personnel (ULP)-C, ULP-G, ULP-H). In addition, the licensee failed to implement personal protective equipment (PPE) guidelines for staff with respect to COVID-19 positive residents. This had the potential to affect all residents, staff, and visitors at 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	0 510			

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0 510	Continued From page 4 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: HAND HYGIENE/GLOVES During the entrance conference on January 12, 2026, at 11:23 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management and assistance with ADLs (activities of daily living) to residents at the facility. ULP-C's Educare (online training platform) Transcript indicated ULP-C completed Infection Control Techniques on September 18, 2024, and July 27, 2025, respectively. In addition, ULP-C's record indicated ULP-C reviewed the licensee's Hand Hygiene, Prevention and Control Program, Procedure for Using Gloves, and Standard (Universal) Precautions for Infection policies on April 12, 2025. ULP-G's Educare Transcript indicated ULP-G completed Infection Control Techniques on June 16, 2025. In addition, ULP-G's record indicated ULP-G reviewed the licensee's Hand Hygiene, Prevention and Control Program, Procedure for Using Gloves, and Standard (Universal) Precautions for Infection policies on April 10, 2025. ULP-H's Educare Transcript indicated ULP-H completed Infection Control Techniques on April 16, 2025. In addition, ULP-H's record indicated ULP-H reviewed the licensee's Hand Hygiene, Prevention and Control Program, Procedure for Using Gloves, and Standard (Universal) Precautions for Infection policies on April 16,	0 510			

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0 510	Continued From page 5 2025. On January 13, 2026, at 7:17 a.m., the surveyor observed ULP-C complete scheduled medication administration for R2. ULP-C compared R2's medication deck (medications set up by the licensee's nurse) to R2's electronic medication administration record (EMAR), placed R2's oral medications into ULP-C's bare hand, placed the medications into a paper cup, entered R2's apartment, administered the oral medication, and returned to the computer to document the administration of medications. The surveyor did not observe ULP-C complete hand hygiene before or after R2's medication administration. On January 13, 2026, at 7:32 a.m., the surveyor observed ULP-C complete scheduled medication administration for R3. ULP-C compared R3's bubble pack (medications set up daily by pharmacy) to R3's EMAR, punched R3's medications out of the bubble packs into ULP-C's bare hand, put the oral medications into a paper cup, entered R3's apartment, administered R3's oral medication, and returned to the computer to document the administration of R3's medications. With bare hands, ULP-C removed the needle from R3's two (2) insulin pens and placed the needles into the sharps container. The surveyor did not observe ULP-C complete hand hygiene before or after R3's medication administration or apply gloves before removing the needles from the insulin pens. On January 13, 2026, at 7:39 a.m., the surveyor observed ULP-C complete scheduled medication administration for R4. ULP-C compared R4's bubble packs to R4's EMAR, placed R4's oral medications into ULP-C's bare hand, put the medications into a paper cup, entered R4's	0 510			

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0 510	Continued From page 6 apartment, administered R4's medications, and returned to the computer to document the administration of R4's medications. The surveyor did not observe ULP-C complete hand hygiene before or after R4's medication administration. On January 13, 2026, at 7:44 a.m., the surveyor observed ULP-G complete scheduled morning medication administration for R5. ULP-G compared R5's bubble packs to R5's EMAR, punched R5's medications out of the bubble pack into a paper cup, administered R5's medications at the dining room table, and returned to the computer to document the administration of R5's medications. The surveyor did not observe ULP-G complete hand hygiene before or after R5's medication administration. On January 13, 2026, at 7:49 a.m., the surveyor observed ULP-G complete scheduled morning medication administration for R6. ULP-G compared R6's bubble packs to R6's EMAR, punched R6's medications out of the bubble packs, entered R6's apartment, administered R6's medications, and returned to the computer to document the administration of R6's medications. The surveyor did not observe ULP-G complete hand hygiene before or after R6's medication administration. On January 13, 2026, at 9:39 a.m., the surveyor observed ULP-C and ULP-H complete a transfer for R9. Without completing hand hygiene, ULP-C and ULP-H entered R9's apartment and transferred R9 from R9's Broda chair to R9's bed. ULP-C and ULP-H both put on gloves, ULP-H wiped R9's peri area, changed R9's brief, and with the same gloved hands rolled R9 towards ULP-H for ULP-C to position the brief under R9. Without completing hand hygiene, ULP-H	0 510			

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0 510	Continued From page 7 removed ULP-H's gloves, put on a new pair of gloves, pulled up R9's pants, and positioned R9 in bed. On January 13, 2026, at 9:54 a.m., ULP-C stated ULP-C was trained to complete hand hygiene in between residents and in between glove use, however, ULP-C may have forgotten to complete hand hygiene each time. ULP-C further stated ULP-C "pops" resident's oral medications into ULP-C's bare hand to ensure the oral medication gets into the paper cup, however, ULP-C stated ULP-C had thought during training ULP-C was trained to placed medications directly into the paper cup and not into ULP-C's hand. On January 13, 2026, at 2:31 p.m., ULP-H stated ULP-H was trained at hire to wash hands or use hand sanitizer in between glove use and in between cares of residents. ULP-H further stated ULP-H usually had a hand sanitizer in ULP-H's pocket, however, ULP-H did not have the hand sanitizer with today (January 13, 2026). On January 13, 2026, at 3:34 p.m., ULP-G stated ULP-G was trained to complete hand hygiene before and after entering a resident apartment along with glove changes. On January 14, 2026, at 9:54 a.m., CNS-B stated hand hygiene was expected to be completed before and after entering a resident apartment, before and after resident cares, prior to serving meals, before and after medication administration, and before and after glove use. CNS-B further stated the licensee had hand sanitizer available on the walls for staff to use for hand hygiene when soap and water were not necessary to use. CNS-B stated ULPs were trained upon hire regarding hand hygiene and	0 510			

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0 510	Continued From page 8 CNS-B was in the process of implementing staff hand hygiene audits every three (3) months. The licensee's undated Procedure for Using Gloves policy indicated to wash hands before and after wearing gloves. The licensee's undated Hand Hygiene policy indicated hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands should be washed after removing gloves. In addition, alcohol-based hand sanitizers may be used instead of soap and water. PPE-MASKS The licensee had signage posted on the front main entrance throughout the survey January 12, 2026, through January 14, 2026, respectively, which indicated the facility had positive COVID-19 residents and mask were required to be worn by staff and visitors. On January 12, 2026, at 10:50 a.m., the surveyor entered the facility and observed owner (O)-E without a mask on in the shared resident living room area. On January 13, 2026, at 11:59 a.m., the surveyor observed cook (C)-K in the assisted living dining room wearing a surgical mask below C-K's nose with another resident present. On January 13, 2026, at 12:22 p.m., the surveyor observed C-K assisting a resident in the dining room. C-K's surgical mask was below C-K's nose. On January 14, 2026, at 1:48 p.m., the surveyor observed C-K calling bingo for several residents	0 510			

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0 510	Continued From page 9 in the dining room. C-K's surgical mask was placed on C-K's chin. On January 14, 2026, at 9:59 a.m., CNS-B stated all staff were required to wear surgical masks throughout the facility due to positive COVID-19 residents. CNS-B further stated surgical masks were to be worn over the nose at all times. CNS-B stated the proper use of PPE, including masks, was included in infection control training for staff. The licensee's undated Covid policy indicated mask are required for all staff and visitors while in the facility during an outbreak, regardless of vaccination status, unless eating or in a private space alone. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630			

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0 630	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R3). 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 January 12, 2026, at 11:18 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. R3's diagnoses included diabetes, hypertension (HTN- high blood pressure), and congestive heart failure (CHF). R3's unauthenticated Service Plan (Waiver)-Addendum to contract dated December 31, 2025, indicated R3's services included medication administration, blood glucose checks, assistance with bathing, and safety checks. On January 13, 2026, at 11:43 a.m., the surveyor observed unlicensed personnel (ULP)-I administer R3's scheduled medication.	0 630			

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0 630	Continued From page 11 R3's Assessment dated December 9, 2025, indicated R3 was not at risk to abuse other vulnerable adults, and R3 was at risk to abuse themselves. R3's record lacked R3's susceptibility to abuse by another individual, including other vulnerable adults. On January 14, 2026, at 2:58 p.m., clinical nurse supervisor (CNS)-B stated R3's assessment lacked R3's susceptibility to abuse by another individual and the question must have been missed on R3's assessment. CNS-B further stated all resident assessments were supposed to include the risk of being abused, the risk of abusing others, and the risk for self-abuse. The licensee's Individual Abuse Prevention Plans policy dated May 20, 2025, indicated the IAPP will include individualized review or assessment of the resident's susceptibility to be abused by another individual, including other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure,	0 650			

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0 650	Continued From page 12 registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-C, ULP-H). 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: During the entrance conference on January 12, 2026, at 9:26 a.m., licensed assisted living	0 650			

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0 650	Continued From page 13 director/licensed practical nurse (LALD/LPN)-A and clinical nurse supervisor (CNS)-B stated the licensee was aware of the required contents of the employee record. ULP-C ULP-C was hired on April 26, 2024, to provide direct care services to residents at the assisted living facility. On January 13, 2026, at 7:17 a.m., the surveyor observed ULP-C administer R2's scheduled morning medication. ULP-C's employee record indicated ULP-C had reviewed Medications Sent Out of the Facility (resident's unplanned time away) policy on January 27, 2025, however, ULP-C's employee record lacked documentation of a training and competency evaluation for resident's unplanned time away. On January 13, 2026, at 7:15 a.m., ULP-C stated ULP-C was trained and competency tested for medication administration, including unplanned time away, upon hire. ULP-H ULP-H was hired on April 10, 2025, to provide direct care services to residents at the assisted living facility. On January 13, 2026, at 9:39 a.m., the surveyor observed ULP-H assist with transferring R9 from R9's Broda chair to R9's bed. ULP-H's employee record indicated ULP-H had reviewed Medications Sent Out of the Facility (resident's unplanned time away) policy on April 21, 2025, however, ULP-H's employee record	0 650			

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0 650	Continued From page 14 lacked documentation of a training and competency evaluation for resident's unplanned time away. On January 13, 2026, at 7:14 a.m., ULP-H stated ULP-H was trained and competency tested for medication administration, including unplanned time away, upon hire. On January 14, 2026, at 10:20 a.m., CNS-B stated unplanned time away training and competency was completed upon hire of any ULP passing medications. On January 14, 2026, at 3:00 p.m., CNS-B stated CNS-B had provided what CNS-B could for employee records, and CNS-B was unable to locate any further employee documents the surveyor requested. The licensee's Personnel Records policy dated May 12, 2025, indicated personnel records for each person will include record of all required training for ULP and competency evaluations. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the	0 650			

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0 650	Continued From page 15 training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=E	144G.42 Subd. 9 Tuberculosis prevention and control (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.	0 660			

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0 660	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of three employees (clinical nurse supervisor (CNS)-B, unlicensed personnel (ULP)-C). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on January 12, 2026, at 11:18 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was completed on January 5, 2026, and the facility was determined to be a low risk level. CNS-B CNS-B was hired on September 22, 2025, to	0 660			

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0 660	Continued From page 17 provide direct care services to residents and supervision of staff at the assisted living facility. Throughout the survey on January 12, 2026, through January 14, 2026, the surveyor observed CNS-B provide direct care services to residents and supervision of staff at the facility. CNS-B's employee record contained a negative QuantiFERON-TB Gold (TB blood test) dated August 26, 2022 (over three years prior to employment start date). CNS-B's employee record lacked documentation of a TB screening and a TB blood draw or two step TST within 90 days of employment start date. On January 14, 2026, at 10:22 a.m., CNS-B stated CNS-B could not recall if CNS-B completed a TB screen upon hire, however, CNS-B was unable to locate of copy of the TB screen. CNS-B further stated the licensee thought a TB blood test was accepted up to five years prior to employment start date, however, CNS-B had just attended a provider group meeting and was informed a TB blood test was only accepted within 90 days of employment. ULP-C ULP-C was hired on April 26, 2024, to provide direct care services to residents at the assisted living facility. On January 13, 2026, at 7:17 a.m., the surveyor observed ULP-C administer R2's scheduled morning medication. ULP-C's employee record contained a negative TB screen and first step TST dated April 26,	0 660			

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0 660	Continued From page 18 2024. ULP-C's employee record included a second step TST administered on May 17, 2024, at 11:00 a.m., and was read on May 19, 2024, at 10:30 a.m. (48 hours had not passed after the TST was administered). On January 14, 2026, at 10:27 a.m., CNS-B stated TSTs were supposed to be read 48 to 72 hours after administration, however, ULP-C's second TST was not accurate as 48 hours had not passed since the administration of the TST. The licensee's undated TB Prevention and Control policy indicated prior to contact with residents, each staff person will be screened for TB either by a two-step skin test or single interferon gamma release assay (IGRA). In addition, after the skin test is administered, the staff must wait 48 to 72 hours and have the skin test reaction read. The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. The MDH Frequently Asked Questions (FAQs) website last updated October 13, 2025, indicated the licensee could accept a TST or IGRA within 90 days of employment start date. No further information was provided.	0 660			

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0 660	Continued From page 19	0 660			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and	0 680			

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0 680	Continued From page 20 visitors of 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). The findings include: During the entrance conference on January 12, 2026, at 11:18 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's electronic EPP, dated February 14, 2025, lacked the following content and/or policies and procedures to address: -the provision of subsistence needs for staff and residents to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting); -evacuation plan to include staff responsibilities during an evacuation; -how the facility will provide a means to shelter in place for residents; -the medical record documentation system the facility has developed to preserve resident information security and availability of records; -the facilities role in providing care and treatment at alternative sites under a 1135 waiver; -a communication plan to include: -a method for sharing information and medical documentation for residents -a method for sharing information from the	0 680			

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0 680	Continued From page 21 emergency plan with residents and their families; and -conduct exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP. On January 14, 2026, from 2:29 p.m. through 2:42 p.m., the surveyor reviewed the licensee's EPP with LALD/LPN-A. LALD/LPN-A stated LALD/LPN-A had started updating the EPP and provided the surveyor with all EPP information the licensee currently used. LALD/LPN-A further stated the EPP lacked specific water supply and information regarding providing services under the 1135 waiver. LALD/LPN-A further stated LALD/LPN-A had thought the EPP had information regarding paper charting, however, LALD/LPN-A was unable to locate the information during interview. On January 14, 2026, at 3:32 p.m., LALD/LPN-A stated the owner told LALD/LPN-A the licensee would not have issues with the sewer as the licensee was on city water and sewer and had a generator for back up. On January 15, 2026, at 11:41 a.m., LALD/LPN-A emailed (electronic mail) the surveyor with handwritten notes listed on the licensee's EPP. The documentation included the following: -added pharmacy and hospice phone numbers; -supply of water: staff will be delegated to go to the grocery store to purchase bulk water for residents use if needed. The supply of water did not indicate how much water was needed for residents and staff; -generator: identify medication equipment requiring electrical power supply. Assure medically necessary equipment has been connected to designated emergency generator	0 680			

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0 680	Continued From page 22 powered outlets if available and supply to sewage or sump pumps; -alternative means of charting: instruct staff to utilize paper charting until systems are restored, however, no instructions on how to obtain the paper charting or if printed off the licensee's electronic medical record system; and -shelter in place: in the event of sever weather, controlled fire, or other reason for partial evacuation, residents may be evacuated to a safe area on the premises (the activity room (the surveyor did not observe an activity room at the assisted living facility) if able or hallway away from danger). If there is a permanent shelter-in-place order this will come from local or state agencies. The licensee's undated Training and Testing policy indicated the facility staff will participate in a full-scale exercise that is community based or if the facility experiences an actual natural or man-made emergency that requires activation of the emergency plan. In addition, the facility will conduct an additional exercise that may include but is not limited to a second full-scaled exercise that is community based or individual, facility-based or a tabletop exercise. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by	0 680			

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0 680	Continued From page 23 reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 775			

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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
0 775	Continued From page 24	0 775			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training was completed for one of two employees (unlicensed personnel (ULP)-C) to include all required content. 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	01380			

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01380	Continued From page 25 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 January 12, 2026, at 9:26 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A and clinical nurse supervisor (CNS)-B stated the licensee was aware of the required contents of the employee record. ULP-C was hired on April 26, 2024, to provide direct care services to residents at the assisted living facility. On January 13, 2026, at 7:17 a.m., the surveyor observed ULP-C administer R2's scheduled morning medication. ULP-C's employee record included an Educare (online training platform) course assignment, which indicated ULP-C was assigned to complete Vital Signs on July 20, 2020, however, the course was not started by ULP-C. In addition, ULP-C was deemed competent to complete a resident's temperature, pulse, and respiration rate on January 16, 2025. ULP-C's employee record lacked documentation of training for reading and recording temperature, pulse, and respirations of the resident. On January 13, 2026, at 7:15 a.m., ULP-C stated upon hire and annually ULPs were assigned by the licensee to complete training courses on Educare. On January 14, 2026, at 10:34 a.m., CNS-B	01380			

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01380	Continued From page 26 stated ULP-C's Educare transcript did not include vital sign (temperature, pulse, and respirations) training and ULP-C should have been assigned to complete the training upon hire. On January 14, 2026, at 12:51 p.m., CNS-B stated ULP-C was assigned to complete vital sign training on Educare, however, ULP-C had not completed the vital sign training course. The licensee's Delegation of Nursing Tasks policy dated May 20, 2025, indicated the registered nurse (RN) will verify the ULP is trained and competent and is instructed in the proper methods to perform the task with respect to the specific resident; if the ULP is not trained, the RN will provide training in-person, verbally, or through other acceptable methods [sic]. The licensee's Personnel Records dated May 12, 2025, indicated the personnel record for each person would include record of all required training for ULP. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems	01440			

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01440	Continued From page 27 and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two employees (unlicensed personnel (ULP)-C). 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 January 12,	01440			

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01440	Continued From page 28 2026, at 9:26 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A and clinical nurse supervisor (CNS)-B stated the licensee was aware of the required contents of the employee record. ULP-C was hired on April 26, 2024, to provide direct care services to residents at the assisted living facility. On January 13, 2026, at 7:17 a.m., the surveyor observed ULP-C administer R2's scheduled morning medication. ULP-C's employee record lacked documentation of a registered nurse (RN) supervising ULP-C performing a delegated task within 30 days of beginning work with the licensee. On January 14, 2026, at 10:32 a.m., CNS-B stated ULPs were expected to have a 30-day direct supervision completed by an RN, however, CNS-B did not know why ULP-C did not have a 30-day supervision as it was prior to CNS-B's employment date. On January 14, 2026, at 3:00 p.m., CNS-B stated CNS-B had provided what CNS-B could for employee records, and CNS-B was unable to locate any further employee documents the surveyor requested. The licensee's Supervision of Licensed and ULP policy dated May 20, 2025, indicated supervision of ULPs by an RN will be direct supervision of the staff performing a delegated task(s) within 30 calendar days after the staff member begins working and first performs the delegated resident tasks.	01440			

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01440	Continued From page 29 The licensee's Performance Review Policy dated May 20, 2025, indicated all new employees will be directly supervised by their supervisor within 30 days of the date they begin work. In addition, the observations will be recorded and retained in the employee file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced	01640			

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01640	Continued From page 30 by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included a resident or resident representative's signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided for one of four residents (R3). 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 January 12, 2026, at 11:18 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. R3's diagnoses included diabetes, hypertension (HTN- high blood pressure), and congestive heart failure (CHF). On January 13, 2026, at 11:43 a.m., the surveyor observed unlicensed personnel (ULP)-I administer R3's scheduled medication. R3's service plan dated December 31, 2025, did not include a resident or resident representative signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided.	01640			

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01640	Continued From page 31 On January 14, 2026, at 2:56 p.m., clinical nurse supervisor (CNS)-B stated CNS-B had revised R3's service plan in December 2025, however, CNS-B did not have R3 sign the revised service plan. CNS-B further stated all resident records were supposed to have signed service plans by the resident, or the resident's representative, and by the licensee. The licensee's undated Service Plans policy indicated service plans and any revisions to services [sic] plans will have a signature or other authentication by the facility and the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced	01760			

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01760	Continued From page 32 by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of two employees (unlicensed personnel (ULP)-C). 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 January 12, 2026, at 11:18 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. ULP-C's employee record indicated ULP-C reviewed the licensee's Insulin Pen policy on January 27, 2025. R3's diagnoses included diabetes, hypertension (HTN- high blood pressure), and congestive heart failure (CHF). R3's unauthenticated Service Plan (Waiver)-Addendum to contract dated December 31, 2025, indicated R3's services included medication administration four times per day. R3's prescriber orders dated September 26, 2025, included orders for Lantus 100	01760			

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01760	Continued From page 33 units/milliliter (mL) inject 15 units subcutaneously (fatty layer between skin and muscle) every 12 hours and Humalog 100 units/mL inject 12 units subcutaneously with breakfast. Hold if blood glucose is less than 80 or resident not eating [sic]. R3's Medication Administration Record (MAR) dated December 2025, and January 2026, respectively, indicated Humalog 100 units/mL administer 12 units subcutaneously with breakfast and Lantus 100 units/mL administer 15 units subcutaneously every 12 hours. On January 13, 2026, at 7:32 a.m., the surveyor observed ULP-C compare R3's Lantus and Humalog insulin pens to R3's electronic medication administration record (EMAR). ULP-C dialed R3's Lantus insulin to 15 units and dialed R3's Humalog insulin pen to 12 units. The surveyor did not observe ULP-C prime either insulin pen with two (2) units of insulin and discard prior to dialing up the dosages of each insulin pen to ensure the needle contained insulin and allowed R3 to get the full dosage of insulin as prescribed. ULP-C entered R3's room, applied the needles to each insulin pen, and administered R3's Lantus and Humalog. On January 13, 2026, at 9:56 a.m., ULP-C stated ULP-C did not prime either of R3's insulin pens prior to administration. ULP-C further stated ULP-C recalled being trained to prime insulin pens, however, ULP-C typically did not prime insulin pens prior to administration of insulin. On January 14, 2026, at 10:06 a.m., clinical nurse supervisor (CNS)-B stated prior to administration of insulin, ULPs were expected to dial the insulin pen to two (2) units and discard to ensure the	01760			

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01760	Continued From page 34 needle was full of insulin. CNS-B further stated after ULPs discarded two (2) units of insulin, ULPs were expected to dial the insulin pen to the prescribed dosage and administer the insulin to the resident. The manufacturer's instructions for Lantus dated May 2016, indicated to always perform a safety test prior to each injection by selecting a dose of two (2) units, press the injection button to ensure insulin comes out of the needle tip, and then proceed to dial the insulin pen to the prescribed dosage for administration. The manufacturer's instructions for Humalog dated March 2013, indicated to prime the Humalog insulin pen prior to each injection by selecting a dose of two (2) units, press the injection button to ensure insulin comes out of the needle tip, and then proceed to dial the insulin pen to the prescribed dosage for administration. The licensee's undated Medication Error policy indicated types of medication errors included administering a dose that is higher or lower than prescribed. In addition, all medication errors and near misses must be reported, documented, and investigated promptly. The licensee's Administration of Medication, Treatment and Therapy by ULP policy dated February 19, 2023, indicated the registered nurse (RN) may delegate administration of medications to ULPs if the RN has instructed the ULP in the proper methods to administer the medications and the ULP demonstrated the ability to competently follow the procedures. No further information was provided.	01760			

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01760	Continued From page 35	01760			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for two of two medication carts (assisted living, memory care). 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on January 12, 2026, at 11:23 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication	01890			

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01890	Continued From page 36 management services to residents at the facility. ASSISTED LIVING MEDICATION CART On January 14, 2026, at 10:43 a.m., the surveyor reviewed the assisted living medication cart with unlicensed personnel (ULP)-G and observed R3's opened Lantus 100 units/milliliter (mL) insulin pen. R3's Lantus insulin pen was not labeled with an open date or expiration date. ULP-G stated ULP-G was trained to write the open date on the insulin pen. MEMORY CARE MEDICATION CART (Dementia Care Unit) On January 14, 2026, at 10:54 a.m., the surveyor reviewed the memory care medication cart with ULP-L and observed opened Lantus 100 units/mL and insulin aspart 100 units/mL insulin pens. The Lantus and insulin aspart insulin pens were not labeled with a prescription label, an open date, or expiration date. ULP-L stated the insulin pens were for R12 and R12 was the only resident administered insulin from the memory care medication cart. ULP-L further stated insulin pens were usually labeled with a pharmacy label and had an open date written on the insulin pen. On January 14, 2026, at 2:47 p.m., CNS-B stated ULPs were trained to label time sensitive medications, including insulin pens, with an open date and expiration date. CNS-B further stated all medications were required to have a prescription label from the pharmacy, and CNS-B was not sure why R12's insulin pens did not have a prescription label. Furthermore, CNS-B completed medication cart audits twice per week to review ULPs labeling of time sensitive medications. The manufacturer's instructions for use of Lantus	01890			

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01890	Continued From page 37 dated May 2019, indicated to discard the Lantus insulin pen 28 days after opening, even if the insulin pen still contains Lantus. The manufacturer's instructions for use of Novolog (insulin aspart) dated February 2015, indicated to discard the Novolog insulin pen 28 days after opening, even if the insulin pen still contains insulin. The licensee's Storage of Medications policy dated May 20, 2025, indicated until the medication is set up for immediate or later administration, a legend drug (medication) must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug strength and quantity of drug, expiration date of the time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications	01910			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER MAPLE WOODS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 33310 STATE HIGHWAY 6 DEER RIVER, MN 56636		
(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
01910	Continued From page 38 remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record all required content for disposition of the medications for one of one resident (R1) upon discharge. 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 January 12, 2026, at 11:23 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. The licensee's Discharged Resident/Client Roster Evaluations dated May 12, 2025, through January	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER MAPLE WOODS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 33310 STATE HIGHWAY 6 DEER RIVER, MN 56636			
(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
01910	Continued From page 39 12, 2026, indicated R1 was admitted to the facility on July 30, 2025, and discharged on September 23, 2025. R1's diagnoses included prostate cancer, chronic heart failure (CHF), and hypertension (HTN-high blood pressure). R1's Service Plan (Private)- Addendum to Contract dated August 6, 2025, indicated R1 received medication administration services twice daily. R1's Med (medication) Admin (Administration) Summary dated September 2025, indicated R1 received the following medications: -acetaminophen (for pain) 1,000 milligrams (mg) twice daily -Amiodarone (for irregular heartbeats) 400 mg daily -aspirin (for heart health) 81 mg daily -clopidogrel (anticoagulant) 75 mg daily -furosemide (for edema) 10 mg daily -Methadone (for pain) 2.5 mg twice daily -metoprolol (antihypertensive) 25 mg daily -Senna-Docusate (for constipation) 8.6-50 daily -hydromorphone (for severe pain) 4 mg every hour as needed -Trazodone/Desyrel (for trouble sleeping) 50 mg daily -lorazepam (for anxiety) 0.25 mg every four hours as needed R1's prescriber orders dated July 31, 2025, September 9, 2025, and September 15, 2025, respectively, included the above noted medications. R1's Discharge/Transfer Summary dated September 23, 2025, indicated R1 was deceased	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER MAPLE WOODS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 33310 STATE HIGHWAY 6 DEER RIVER, MN 56636		
(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
01910	Continued From page 40 on September 16, 2025, under the care of hospice. R1's Medication Disposition- Resident dated September 1, 2025, through September 30, 2025, included all medications noted above, however, lacked the prescription numbers for Methadone and furosemide. On January 14, 2026, at 2:50 p.m., CNS-B stated CNS-B was not surprised some of R1's medications lacked prescription numbers. CNS-B further stated when CNS-B started employment with the licensee CNS-B updated the licensee's electronic medical record system to ensure each resident medication included a prescription number as required. The licensee's undated Disposition or Disposal of Medication policy indicated documentation of the medication destruction would include the prescription number. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER MAPLE WOODS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 33310 STATE HIGHWAY 6 DEER RIVER, MN 56636		
(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
02310	Continued From page 41 Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of two residents (R7) with hospital bed rails. 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 January 12, 2026, at 11:18 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee was familiar with current minimum assisted living requirements. R7's diagnoses included seizure disorder, traumatic brain injury (TBI), and depression. R7's Service Plan (Waiver)- Addendum to Contract dated October 27, 2025, indicated R7's services included medication administration, dressing, grooming, transfers, toileting, and housekeeping. On January 13, 2026, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-C and ULP-G complete a brief change for R7. During the observation, the surveyor observed upper bilateral hospital bed rails on R7's bed. R7's Restraint/ Entrapment Assessment dated	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER MAPLE WOODS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 33310 STATE HIGHWAY 6 DEER RIVER, MN 56636			
(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
02310	Continued From page 42 June 20, 2025, indicated R7 had ½ side rails (bed rails) and included the following: -R7 was alert and orientated; -R7 took psychotropic, epileptic, and antihistamine medications; -R7 used the bed rails for positioning and support; -R7 expressed desire to have bed rails; -R7 was incontinent; -R7 bed rails did not limit freedom of movement, sensory stimulation, obstruct R7's view, or limit access to their person or environment; -risk and benefits were discussed with R7; -R7 refused potential alternatives for bed rails; -the bed rails were assessed to be not a restraint for R7 and recommended for use; and -Zone 1: no measurement documented, Zone 2: three inches, Zone 3: ¼ inch, Zone 4: two inches R7's Assessment dated October 27, 2025, indicated R7 had side rails (bed rails) to assist with bed mobility, bed rails are appropriate based upon assessment, and the bed rails do not function as a restraint. R7 took medications that affect mental status, no alternatives to use in place of bed rails, and R7 has been education of the risks and benefits of the bed rails. See bed rail assessment (noted above) in documents. R7's record lacked evidence of documentation of the zone measurements for zones 1, 2, 3, and 4 every 90 days. On January 14, 2026, at 3:03 p.m., clinical nurse supervisor (CNS)-B stated R7 would not allow CNS-B to complete measurements of zones 1, 2, 3, and 4 on bed rails with R7's last assessment. CNS-B further stated the registered nurse (RN) was expected to measure each zone of the bed rail and document the findings every 90 days to	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER MAPLE WOODS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 33310 STATE HIGHWAY 6 DEER RIVER, MN 56636		
(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
02310	Continued From page 43 ensure no changes had occurred with the bed rails. The licensee's undated Devices and Device Assessment/Bed Rails policy indicated documentation will be entered in the resident's record to include results of the assessment (bed rail assessment). The policy did not address measurement documentation of each bed rail zone. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated October 13, 2025, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
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02310	Continued From page 44 interventions to mitigate safety risk or negotiated risk agreements." Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310			
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.	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
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02320	Continued From page 45 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for medication setup by unlicensed personnel (ULP) for one of one resident (R8). 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 January 12, 2026, at 11:23 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R8's diagnoses included dementia and depression. R8's Service Plan (Private)- Addendum to Contract dated July 15, 2025, indicated R8's services included medication administration five times per day by the ULP. R8's prescriber orders dated April 22, 2025, included orders for Baclofen (for muscle spasms) 10 milligrams (mg) three times daily, Clonazepam (antianxiety) 0.25 mg twice daily, Lamotrigine (mood stabilizer) 100 mg daily, omeprazole	02320			

Minnesota Department of Health

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02320	Continued From page 46 (antacid) 20 mg twice daily, Phospha (supplement) 250 twice daily, and Senexon-S (for constipation) 8.6-50 mg twice daily. On January 13, 2026, at 8:31 a.m., the surveyor observed ULP-G compare R8's scheduled morning medication, noted above, to the electronic medication administration record (EMAR), put the medications into a paper cup, and brought the medications to R8. ULP-G encouraged R8 to take the medications, however, R8 refused to take the medications. ULP-G wrote R8's room number on the paper cup and placed the paper cup back into the medication cart. On January 13, 2026, at 8:55 a.m., the surveyor observed ULP-G remove R8's medications out of the medication cart and handed the paper cup to ULP-C. ULP-C stated ULP-C will attempt to administer R8's scheduled morning medication. On January 13, 2026, at 9:16 a.m., the surveyor observed ULP-C hand ULP-G R8's empty paper cup and ULP-C stated the medications were administered to R8. ULP-G logged into R8's EMAR and documented R8's scheduled morning medication as administered with a note, "administered late by a different staff due to resident refusing from this staff." On January 13, 2026, at 9:58 a.m., ULP-C stated if a resident refuses to take medications, then another ULP will attempt to administer the medications. ULP-C further stated the staff member who administered the medications is responsible for documenting the medications as administered, however, ULP-C reported to ULP-G R8's medications were administered so it was okay for ULP-G to document the administration.	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
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02320	Continued From page 47 On January 13, 2026, at 3:32 p.m., ULP-G stated if a resident refused to take medications after two attempts from a ULP, then another ULP would attempt to administer the medications to a resident. ULP-G further stated R8's medications were set up by ULP-G and given to ULP-C this morning since R8 refused to take the medications from ULP-G. On January 14, 2026, at 10:09 a.m., CNS-B stated ULPs were expected to reapproach a resident three different times if a resident refused to take their medication. CNS-B further stated if another ULP attempts to administer a resident medication that is already set up, the ULP needs to reverify the medications listed on the EMAR, confirm each medication by description, administer the medication to the resident, and document the administration of the medications. The licensee's Administration of Medication, Treatment and Therapy by ULP policy dated February 19, 2023, indicated ULP that will provide assistance with medication administration will be trained and competent to follow the following procedure: complete procedures for checking the resident's medication administration record (MAR), follow infection control precautions, prepare medications, administer the medications, and document after administration. MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2026
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02320	Continued From page 48 days	02320			



Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

MAPLE WOODS ASSISTED LIVING
33310 STATE HIGHWAY 6
Deer River, MN 56636
Itasca County
Parcel:
Phone:

License Info

License: HFID 33975

Risk:
License:
Expires on:
CFPM: Carla Hodgson
CFPM #: 83342; Exp: 04/20/2028

Inspection Info

Report Number: F8046261007
Inspection Type: Full - Single
Date: 1/12/2026 Time: 12:43:06 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery:

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 Priority Level: Priority 2 CFP#: 48

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

COMMENT: ESTABLISHMENT DID NOT HAVE TEST STRIPS ON SITE FOR DISH MACHINE. SEVERAL STRIPS WERE PROVIDED. NEED QUATERNARY AMMONIA TEST STRIPS FOR SPRAY BOTTLE MIXING VALVE IN LAUNDRY ROOM.

Comply By: 1/19/2026 Originally Issued On: 1/12/2026

! New Order: 4-500 Equipment Maintenance and Operation

4-501.114C1 Priority Level: Priority 1 CFP#: 16

MN Rule 4626.0805C1 Provide and maintain an approved chlorine chemical sanitizer solution that has a minimum concentration of 50 ppm and a minimum temperature of 75 degrees F (24 degrees C) for water with a pH of 8 or less or a minimum temperature of 100 degrees F (38 degrees C) for water with a pH of 8.1 to 10.

COMMENT: OBSERVED DISH MACHINE NOT REACHING SANITIZE CONCENTRATION OF CHLORINE. DIP TUBE WAS BROKEN. REPAIRED ON SITE.

Comply By: Complied On Site Originally Issued On: 1/12/2026

Food & Beverage General Comment

DISCUSSED TESTING DISH MACHINE W/TEST STRIPS. HANDOUTS PROVIDED: PIC, HANDWASHING, TCS FOODS, COOLING, REHEATING, PERSONAL HYGIENE, DATEMARKING, ILLNESS LOG, COOLING LOG.

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 Bemidji District Office inspection report number F8046261007 from 1/12/2026

Zach Johnson

Hannah
Cook

Zach Johnson,
Public Health Sanitarian
218-308-2108
zach.johnson@state.mn.us



Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Page: 1

Establishment Info

MAPLE WOODS ASSISTED LIVING
Deer River
County/Group: Itasca County

Inspection Info

Report Number: F8046261007
Inspection Type: Full
Date: 1/12/2026
Time: 12:43:06 PM

Equipment Temperature: Product/Item/Unit: 3 door reach in; **Temperature Process:** Cold-Holding

Location: kitchen at 38 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: shepards pie; **Temperature Process:** Cooking

Location: at 168 Degrees F.

Comment:

Violation Issued?: No



Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Page: 1

Establishment Info

MAPLE WOODS ASSISTED LIVING
Deer River
County/Group: Itasca County

Inspection Info

Report Number: F8046261007
Inspection Type: Full
Date: 1/12/2026
Time: 12:43:06 PM

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 0 PPM

Comment:

Violation Issued?: Yes

Sanitizing Equipment: Product: Chlorine; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 50 Degrees F.

Comment: dish machine repaired on site.

Violation Issued?: No



Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info Maple Woods 33310 State Hwy 6 Deer River, MN 56635 Crow Wing County Parcel: Phone:	License Info License: HFID 33975 Risk: License: Expires on: CFPM: CFPM #: ; Exp:	Inspection Info Report Number: F8046261011 Inspection Type: Follow-up - Single Date: 1/22/2026 Time: 8:55:03 AM Duration: minutes Announced Inspection: <u>Total Priority 1 Orders: 0</u> <u>Total Priority 2 Orders: 0</u> <u>Total Priority 3 Orders: 0</u> <u>Delivery:</u>
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No orders were issued for this inspection report.

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 Bemidji District Office inspection report number F8046261011 from 1/22/2026

Zach Johnson

Establishment Representative

Zach Johnson,
Public Health Sanitarian
218-308-2108
zach.johnson@state.mn.us

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: 33975-016	Date: 1/12/2026
Facility Name: Maple Woods Assisted Living	
Facility Address: 33310 State Highway 6 Deer River, MN 56636	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Initiation of the fire alarm system in I-1 occupancies shall be by manual and automatic means. Approved automatic fire detectors shall be installed in laundry and soiled linen rooms, boiler and furnace rooms, mechanical and electrical rooms, shops, laboratories, kitchens, locker rooms, custodial closets, trash-collection rooms, storage rooms, lounges, gift shops, and similar areas. Automatic smoke detectors shall be provided in corridors and areas that are open to corridors.

Initiation of the fire alarm system in I-2 occupancies shall be by manual and automatic means. Approved automatic fire detectors shall be installed in laundry and soiled linen rooms, boiler and furnace rooms, mechanical and electrical rooms, shops, laboratories, kitchens, locker rooms, custodial closets, trash-collection rooms, storage rooms, lounges, gift shops, and similar areas. Hospitals, nursing homes (both intermediate care and skilled nursing facilities), board and care homes, and detoxification facilities shall be provided with smoke detection throughout the corridor and areas open to the corridors, other than nurses' stations. [Minn. Stat. 144G.45 subd. 2; MSFC 907.2.6.1.1; 907.2.6.2.1]

Comments: There was not a fire alarm system present in the building with smoke detection in the areas required by the Minnesota State Fire Code for I-1 or I-2 facilities, as this facility is designated.

3. Multiplug adapters, such as cube adapters, unfused plug strips or any other device not complying with NFPA 70 shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4]

Comments: Resident room #12-refrigerator and microwave were plugged into a wall power tap.

4. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed

within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: No carbon monoxide protection was provided for the facility.

Installation. The installation of nonportable gas-fired appliances and systems shall comply with the International Fuel Gas Code. The installation of nonportable liquid fuel fired appliances and systems shall comply with this section and the International Mechanical Code. The installation of all other fuel-fired appliances, other than portable internal combustion engines, oil lamps and other portable devices such as blow torches, melting pots and weed burners, shall comply with this section and the International Mechanical Code. [MSFC 603.1]

Comments: The moveable kitchen equipment was not provided with a restraint cable.

5. Valves controlling the water supply for *automatic sprinkler systems*, pumps, tanks, water levels and temperatures, critical air pressures and waterflow switches on all sprinkler systems shall be electrically supervised by a *listed* fire alarm control unit. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4]

Comments: The fire sprinkler system valves and the fire sprinkler flow switch were not connected to and supervised by a listed fire alarm control unit.

6. Required fire protection systems. Fire protection systems required by this code or the International Building Code shall be installed, repaired, operated, tested and maintained in accordance with this code. A fire protection system for which a design option, exception or reduction to the provisions of this code or the International Building Code has been granted shall be considered to be a required system. [Minn. Stat. 144G.45 subd. 2; MSFC 901.4.1]

Comments: There was a fire sprinkler head missing in the south corridor.