STATE LICENSING COMPLIANCE REPORT

Report #: HL213877228C

Date Concluded: July 21, 2025

Name, Address, and County of Facility Investigated:
Rose Arbor/Wildflower Lodge
16500 92nd Avenue North
Maple Grove, MN 55331
Hennepin County

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

Evaluator's Name: Erin Johnson-Crosby, RN
Special Investigator

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21387	A. BUILDING: _____ B. WING _____	C 06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE ARBOR/WILDFLOWER LODGE	16500 92ND AVENUE NORTH MAPLE GROVE, MN 55311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL213877228C On June 23, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 100 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction order is issued for #HL213877228C, tag identification 0320.	0 000		
0 320 SS=D	144G.30 Subdivision 1 Regulatory powers (a) The Department of Health is the exclusive state agency charged with the responsibility and duty of surveying and investigating all assisted living facilities required to be licensed under this chapter. The commissioner of health shall enforce all sections of this chapter and the rules	0 320		

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0 320	Continued From page 1 adopted under this chapter. (b) The commissioner, upon request to the facility, must be given access to relevant information, records, incident reports, and other documents in the possession of the facility if the commissioner considers them necessary for the discharge of responsibilities. For purposes of surveys and investigations and securing information to determine compliance with licensure laws and rules, the commissioner need not present a release, waiver, or consent to the individual. The identities of residents must be kept private as defined in section 13.02, subdivision 12. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to provide access to relevant information, records, incident reports, and other documents when necessary when the licensee failed to respond timely to state triage requests for resident and staff records to determine compliance to licensure laws and rules. 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: The licensee did not provide requested information to the state triage team in a timely manner for requests made regarding five different	0 320	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	

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0 320	Continued From page 2 incidents. Documentation reviewed included an email dated April 11, 2025, at 11:32 a.m., from state triage staff requesting documentation be provided by April 14, 2025. No response was provided by the licensee. -On April 15, 2025, at 4:32 p.m., triage staff sent another email to the licensee requesting the same documents. No response was provided by the licensee. -On April 17, 2025, at 10:18 a.m., triage staff again requested the documents. No response was provided by the licensee. -On April 17, 2025, at 10:46 a.m., the licensee replied she would check with other staff about the request; however, the facility did not respond to the record requests made by the state agency. An email dated April 18, 2025, 2:38 p.m., was sent by the state triage staff requesting documents by April 22, 2025. No response was provided by the licensee. -On April 23, 2025, at 10:02 a.m., the licensee emailed documents. -On April 23, 2025, at 10:51 a.m., triage staff emailed the licensee with follow up questions. No response to the questions was provided until May 1, 2025 at 10:09 a.m. An email dated May 1, 2025, at 3:24 p.m., sent by state triage staff requested documents be provided by May 5, 2025. -The licensee responded on May 6, 2025, at 12:55 p.m., indicating the nurse who was assisting with this was not available and would send the documents ASAP (as soon as possible). -On May 7, 2025, at 2:35 p.m., triage staff informed the licensee the requested records had not been received. On May 7, 2025 at 3:48 p.m.,	0 320	WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 320	Continued From page 3 the licensee sent the requested documents to triage staff. An email dated June 9, 2025, at 4:38 p.m., sent by state triage staff requested information be provided by June 10, 2025. -On June 9, 2025, at 4:38 p.m., the licensee responded that they were working on the request. -On June 11, 2025, at 11:07 a.m., state triage staff emailed the licensee asking if the documents would be sent by the end of the day. -On June 11, 2025, at 2:26 p.m., the licensee indicated they were working with their legal department before sending the documents. -Again on June 11, 2025, at 5:07 p.m., the licensee responded again indicating the legal team had a couple questions so the requested documented would not be able to be sent that night. -On June 13, 2025, at 10:07 a.m., the licensee sent all of the requested information. An email dated July 8, 2025, at 10:36 a.m., sent by state triage staff requested the following information be provided by July 10, 2025: resident care plan, incident report related to the incident, and progress notes for June. On July 10, 2025, at 2:21 p.m., the licensee responded that they sent the resident care plan and June progress notes, but was not able to provide a copy of the incident report per their legal department and the additional requested information was not provided by the licensee to the state department. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	0 320		