



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 12, 2025

Licensee

Havenwood of Maple Grove
18695 73rd Avenue North
Maple Grove, MN 55311

RE: Project Number(s) SL37128016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 25, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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 . . ."

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 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>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor

State Evaluation Team

Email: Kelly.Thorson@state.mn.us

Telephone: 320-223-7336 Fax: 1-866-890-9290

AH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE		STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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	<p>Initial Comments</p> <p>***ATTENTION***</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>SL37128016-0</p> <p>On June 23, 2025, through June 25, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 142 residents; 44 residents receiving services under the Assisted Living Facility with Dementia Care license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.</p>		
0 100 SS=F	<p>144G.10 Subdivision 1 License required</p> <p>(a)(1) Beginning August 1, 2021, no assisted</p>	0 100			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
0 100	<p>Continued From page 1</p> <p>living facility may operate in Minnesota unless it is licensed under this chapter.</p> <p>(2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e).</p> <p>(b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.</p> <p>(c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type.</p> <p>(d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.</p> <p>(e) Upon approving an application for an assisted</p>	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
0 100	<p>Continued From page 2</p> <p>living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to obtain accurate licensure when they applied for licensure for an assisted living facility, despite sharing one roof with adjoining therapy gym facility, without having evidence of an approved two-hour fire barrier wall.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On June 24, 2025, at 10:30 a.m. engineering staff toured the facility with director of maintenance (DOM)-G. The facility had a licensed therapy gym that was open for public use with membership</p>	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
0 100	<p>Continued From page 3</p> <p>that was located in the middle of the assisted living building. The assisted living licensing requires the wall separating licensed assisted living facilities from another licensed facility or another occupancy in the same building, to be constructed as a 2-hour fire barrier wall. The licensee was unable to provide evidence that two-hour fire walls existed between the two dwellings.</p> <p>On June 25, 2025, at 8:47 a.m., licensed assisted living director (LALD)-C provided surveyor with the therapy contract and stated, "This is the contract for the therapy, they rent the space from us. They have their own license as they are outsourced. Anyone from the public can get a membership and use the therapy gym."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) Days</p>	0 100			
0 480 SS=F	<p>144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services</p> <p>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.</p> <p>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:</p> <p>(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</p>	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
0 480	Continued From page 4 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 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.	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE		STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
0 480	<p>Continued From page 5</p> <p>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.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 the residents).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 24, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> <p>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.</p>	0 480			
0 650 SS=E	<p>144G.42 Subd. 8 (a) Staff records</p> <p>(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</p>	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
0 650	<p>Continued From page 6</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of four employees (unlicensed personnel (ULP)-B, registered nurse (RN)-F).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).</p> <p>The findings include:</p> <p>ULP-B ULP-B was hired on April 15, 2024, to provide</p>	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
0 650	<p>Continued From page 7</p> <p>direct care services to residents.</p> <p>On June 23, 2025, at 12:05 p.m., surveyor observed ULP-B administer medications for R9.</p> <p>ULP-B's record included two competency evaluations titled 2.43 Transfers & Ambulation Techniques and 2.35 Unplanned Time Away Medication Set Up completed June 24, 2025, during the survey. ULP-B's personnel file lacked the following required content completed prior to the survey:</p> <ul style="list-style-type: none">- competency evaluation which included:<ul style="list-style-type: none">- standby assistance techniques and how to perform them;- safe transfer and ambulation; and- setting up medications for an unplanned time away from home. <p>RN-F was a contracted nurse hired by the licensee on April 10, 2025, to provide supervision and oversight to ULP, and to provide direct care services to residents.</p> <p>RN-F's personnel file lacked the following required content:</p> <ul style="list-style-type: none">- orientation to assisted living regulations which included:<ul style="list-style-type: none">- overview of assisted living statutes;- review of provider's policies and procedures;- handling emergencies and using emergency services;- reporting maltreatment of vulnerable adults or minors;- assisted living bill of rights;- handling of resident complaints, reporting complaints, where to report;- consumer advocacy services;- review of types of assisted living services	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
0 650	<p>Continued From page 8</p> <p>the employee would provide and providers scope of license;</p> <ul style="list-style-type: none">- principles of person-centered planning/service delivery; and- dementia training required for all direct care staff and supervisors. <p>On June 25, 2025, at 9:03 a.m., clinical nurse supervisor (CNS)-D stated ULP-B remembered completing the competency evaluations upon hire however, the competency evaluations were completed on June 24, 2025, because they could not find the competency evaluations in ULP-B personnel file.</p> <p>On June 25, 2025, at 9:35 a.m., ULP-B stated they completed the competency evaluation listed above upon hire with a nurse.</p> <p>On June 25, 2025, at 10:42 a.m., CNS-D stated RN-F was the first contracted nurse the licensee hired. CNS-D stated RN-F completed computer training, shadowing on the floor, and discussed with RN-F the orientation topics listed above. CNS-D stated they did not document RN-F's orientation.</p> <p>On June 25, 2025, at 10:52 a.m., RN-F stated they received training on all the orientation content listed above. In addition, RN-F stated they received eight hours of dementia training within the last year at a different facility.</p> <p>The licensee's Assisted Living Orientation-ULP Staff dated October 2024, indicated ULP who were not registered nursing assistant would receive additional training on the following topics with a written or oral competency test and skills demonstration:</p> <ul style="list-style-type: none">- standby assistance techniques;	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
0 650	<p>Continued From page 9</p> <p>- safe transfer techniques and ambulation; and - medication preparation for leave of absence.</p> <p>The licensee's Assisted Living & Assist Living with Dementia Care Orientation - All Staff policy dated October 2024, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. Orientation to assisted living facility licensing requirements and regulations is only required upon hire and is provided by the licensee. Orientation provided by a previous organization is not transferable to the licensee.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 650			
01370 SS=D	<p>144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn</p> <p>(a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and</p>	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01370	<p>Continued From page 10</p> <p>(iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of three unlicensed personnel (ULP-E).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p>	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE		STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01370	<p>Continued From page 11</p> <p>The findings include:</p> <p>ULP-E was hired on May 20, 2024, to provide direct care services to residents.</p> <p>On June 23, 2025, from 12:08 p.m. through 12:13 p.m., surveyor observed ULP-E administer medication to R8.</p> <p>ULP-E's employee records lacked documentation of training and competency evaluations for ULP's providing assisted living services including: awareness of commonly used health technology equipment and assistive devices.</p> <p>On June 24, 2025, at 1:58 p.m., clinical nurse supervisor (CNS)-D stated, "So, [ULP-E] does not have that training, and we have pulled her off the schedule until she completes her training. The other training we can't find that, so she does not have that."</p> <p>The licensee's Assisted Living Orientation-ULP Staff dated October 2024, indicated ULP who were not registered nursing assistants would receive addition training with a written or oral competency test on commonly used health technology equipment and assistive devices.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01370			
01470 SS=D	<p>144G.63 Subd. 2 Content of required orientation</p> <p>(a) The orientation must contain the following topics:</p>	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01470	<p>Continued From page 12</p> <p>(1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p>	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01470	<p>Continued From page 13</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;</p> <p>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee orientation included all required content for one of three employees (unlicensed personnel (ULP-E).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>ULP-E was hired on May 20, 2024, to provide direct care services to residents.</p> <p>On June 23, 2025, from 12:08 p.m. through 12:13</p>	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01470	<p>Continued From page 14</p> <p>p.m., surveyor observed ULP-E administer medication to R8.</p> <p>ULP-E's employee records lacked orientation to assisted living regulations to include the following:</p> <ul style="list-style-type: none">- Principles of person-centered planning/service delivery; <p>On June 24, 2025, at 1:58 p.m., clinical nurse supervisor (CNS)-D stated, "So, [ULP-E] does not have that training, and we have pulled her off the schedule until she completes her training. The other training we can't find that, so she does not have that."</p> <p>The licensee's Assisted Living & Assist Living with Dementia Care Orientation - All Staff policy dated October 2024, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. In addition, orientation would include principles of person-centered planning and service delivery and how they apply to direct support services.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01470			
01540 SS=D	<p>144G.64 (a) (3) Training in Dementia, Mental Illness, and De-</p> <p>(3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide</p>	01540			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01540	<p>Continued From page 15</p> <p>direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of three employees (unlicensed personnel (ULP-E) completed the required amount of dementia care training in the required time frame.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>ULP-E was hired on May 20, 2024, to provide direct care services to residents.</p>	01540			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE		STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01540	<p>Continued From page 16</p> <p>On June 23, 2025, from 12:08 p.m. through 12:13 p.m., surveyor observed ULP-E administer medication to R8.</p> <p>ULP-E's employee file contained initial dementia Educare training (an electronic training software) totaling five and a half hours, but lacked a total of eight training hours on dementia.</p> <p>On June 24, 2025, at 1:58 p.m., clinical nurse supervisor (CNS)-D stated, "So, [ULP-E] does not have that training, and we have pulled her off the schedule until she completes her training. The other training we can't find that, so she does not have that."</p> <p>The licensee's Dementia Training policy dated October 2024, indicated employees of a assisted living with dementia care who have not completed their initial dementia care training would not provide direct care independently. In addition, direct-care employees would complete a minimum of eight hours initial training on dementia care topics within 80 working hours from employment start date.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01540			
01620 SS=F	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.</p> <p>(b) An assisted living facility shall conduct a</p>	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01620	<p>Continued From page 17</p> <p>nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.</p> <p>(c) Resident reassessment and monitoring must be conducted by a registered nurse:</p> <p>(1) no more than 14 calendar days after initiation of services;</p> <p>(2) as needed based on changes in the resident's needs; and</p> <p>(3) at least every 90 calendar days.</p> <p>(d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment.</p> <p>(e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.</p> <p>(f) A facility must inform the prospective resident of the availability of and contact information for</p>	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01620	<p>Continued From page 18</p> <p>long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed every 90-days for three of three residents (R6, R7, R8).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents)</p> <p>The findings include:</p> <p>R6 admitted to the licensee and began receiving assisted living services on October 15, 2022.</p> <p>R6's diagnoses included Alzheimer's, adjustment disorder mixed with anxiety and depression, and diabetes mellitus type two (DM2).</p> <p>R6's Service Plan signed November 13, 2024, indicated R6 received assistance with bathing reminders, escorts, housekeeping, laundry, medication administration, toileting, and blood glucose monitoring.</p> <p>R6's record included 90-day ongoing</p>	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01620	<p>Continued From page 19</p> <p>comprehensive assessments dated July 31, 2024, November 13, 2024, and February 18, 2025, indicating 105 days passed between R6's July and November assessment, 97 days passed between R6's November and February assessment, and 125 days passed between R6's February assessment and the start of survey.</p> <p>R7 R7 admitted to the licensee and began receiving assisted living services on September 29, 2022.</p> <p>R7's diagnoses included type 2 diabetes, hypertension, and dementia.</p> <p>R7's unsigned signed Service plan, dated effective as of April 10, 2025, indicated R7's services included bathing, grooming, blood glucose monitoring, medication administration, housekeeping, laundry, ambulation, toileting, transfers, monthly vitals, and dressing.</p> <p>R7's record included comprehensive assessments dated October 22, 2024, and February 17, 2025, indicated 119 days had passed between assessments, and a comprehensive assessment dated March 18, 2025, indicated 99 days had passed since R7's last assessment.</p> <p>R8 R8 admitted to the licensee and began receiving assisted living services on January 29, 2024.</p> <p>R8's diagnoses included hypertension and dementia.</p> <p>R8's unsigned signed Service plan, dated effective as of May 30, 2025, indicated R8's services included monthly vitals, toileting,</p>	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE		STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01620	<p>Continued From page 20</p> <p>medication administration, grooming, housekeeping, bathing, dressing, and laundry.</p> <p>R8's record included comprehensive assessments dated November 13, 2024, and February 13, 2025, indicated 92 days had passed between assessments, and 132 days had passed since R8's last assessment.</p> <p>On June 24, 2025, at 1:03 p.m., clinical nurse supervisor (CNS)-D stated the R6 did not have any more assessments completed after February 18, 2025.</p> <p>On June 24, 2025, at 1:17 p.m., during interview with CNS-D and Regional registered nurse (RRN)-A, CNS-D stated ongoing assessments were late because they were the only RN in the facility, and they used intermittent family medical leave for personal reasons. CNS-D stated, "I am trying to keep things afloat." CNS-D stated the licensee was now fully staffed with RNs. RRN-A stated the licensee should be catching up with resident assessments as the licensee is fully staffed with RNs.</p> <p>The licensee's Initial and On-going Nursing Assessment of Resident policy dated May 19, 2025, indicated nursing assessments were completed by a registered nurse based upon the required assessment schedule and as needed based upon the resident condition. In addition, ongoing assessments were completed periodically but no less than every 90-days.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01640	Continued From page 21	01640			
01640 SS=E	<p>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</p> <p>(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.</p> <p>(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.</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(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.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for two of three residents (R7 and R8).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a</p>	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01640	<p>Continued From page 22</p> <p>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).</p> <p>The findings include:</p> <p>R7 R7 was admitted to the licensee and began receiving assisted living services on September 29, 2022.</p> <p>R7's diagnoses included type 2 diabetes, hypertension, and dementia.</p> <p>R7's unsigned signed Service plan, dated effective as of April 10, 2025, indicated R7's services included bathing, grooming, blood glucose monitoring, medication administration, housekeeping, laundry, ambulation, toileting, transfers, monthly vitals, and dressing.</p> <p>R7's current service plan lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided.</p> <p>R8 R8 was admitted to the licensee and began receiving assisted living services on January 29, 2024.</p> <p>R8's diagnoses included hypertension and dementia.</p> <p>R8's unsigned signed Service plan, dated</p>	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01640	<p>Continued From page 23</p> <p>effective as of May 30, 2025, indicated R8's services included monthly vitals, toileting, medication administration, grooming, housekeeping, bathing, dressing, and laundry.</p> <p>R8's current service plan lacked a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided.</p> <p>On June 24, 2025, at 11:11 a.m., clinical nurse supervisor (CNS)-D stated, "We unfortunately don't have one for [R7], his family is out of town, we call the family and let them know there is a new service plan to sign, and they say when they visit next time they will sign it then, they should be documenting it but as there is not a progress note then it wasn't documented, but they should be documenting those calls, that is the process that we use for everyone, at least every resident that has family out of town or not able to come in for the meetings, we just have them sign when they visit next."</p> <p>The licensee's Contents of Service Plans policy dated October 24, 2025, indicated service plans and any revisions to the services plan will have a signature or other authentication by the facility and by the resident. Other authentication could be email confirming accepting terms of a service agreement or other method deemed appropriate by the assisted living facility.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE		STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01750	Continued From page 24	01750			
01750 SS=D	<p>144G.71 Subd. 7 Delegation of medication administration</p> <p>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:</p> <p>(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;</p> <p>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and</p> <p>(3) communicated with the unlicensed personnel about the individual needs of the resident.</p> <p>This MN Requirement is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the licensee failed to ensure specific medication administration instructions for each resident was documented in the resident's record for one of four residents (R8).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R8 was admitted to the licensee and began receiving assisted living services on January 29, 2024.</p>	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01750	<p>Continued From page 25</p> <p>R8's diagnoses included hypertension and dementia.</p> <p>R8's unsigned signed Service plan, dated effective as of May 30, 2025, indicated R8's services included monthly vitals, toileting, medication administration, grooming, housekeeping, bathing, dressing, and laundry.</p> <p>On June 23, 2025, at 12:08 p.m., survey observed unlicensed personnel (ULP)-E administer medications including dorzolamide 2 percent (%) eye drops and latanoprost 0.005% eye drops to R8. ULP-E administered one drop of dorzolamide 2% into each of R8's eyes and then immediately before surveyor could intervene, proceded to place one drop of latanoprost 0.005% into each of R8's eyes. R8's eMar Summary record indicated, "dorzolamide 2% eye drops instill 1 drop into each eye once daily" and "latanoprost 0.005% eye drop instill 1 drop into each eye once daily". R9's record lacked specific instructions for how long to wait between eye drops.</p> <p>On June 23, 2025, at 12:20 p.m., ULP-E stated, "I don't remember any training on eye drops or how long I am supposed to wait."</p> <p>On June 24, 2025, at 12:42 p.m., registered nurse (RN)-A stated, "Does it have to be written if they are taught to wait 5 minutes between eye drops? Because we don't have it, if you can't see it, we don't have it."</p> <p>The licensee's Delegation of Nursing Taks dated October 24, 2025, indicated when needed the RN or licensed practical nurse (LPN) would provide written instructions for performing the procedure to the ULP.</p>	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01750	Continued From page 26 The licensee's Individualized Medication, Treatment & Therapy Management Plans policy dated October 2024, indicated the RN would develop a medication management plan for each resident receiving medication management services and the medication management plan would include documentation of specific resident instructions relating to the administration of medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescription medications were stored according to the manufacturer's directions. 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	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01880	<p>Continued From page 27</p> <p>portion or all of the residents).</p> <p>The findings include:</p> <p>On June 23, 2025, at 11:58 a.m., the surveyor observed the licensee's only medication refrigerator and observed one bottle of latanoprost 0.005 percent (%) for R5 and four Novolog FlexPens 100 units (u)/ milliliter (ml) for R4's. The thermometer for the medication refrigerator read 76 degrees Fahrenheit (F) however, the refrigerator felt an undeterminable amount colder than what the thermometer read. Regional registered nurse (RRN)-A stated, "temp says 76.0 but really it is not that cold the fridge feels cold and there is frost on the shelves." RRN-A stated they believed the thermometer was not working appropriately. Clinical nurse supervisor (CNS)-D joined the conversation and stated they had another staff member program the thermometer and did not know how it worked. CNS-D provided the medication refrigerator log to the surveyor which indicated from June 1, 2025, through June 17, 2025, the medication refrigerator was between 74.2 degrees F and 81.1 degrees F. CNS-D stated, "Why have they not reported this." CNS-D stated there have been no reports of the medication refrigerator being out of range. CNS-D stated nurses were trained to read and document the medication refrigerator temperature daily and report if the degrees in F fall out of the medication range.</p> <p>On June 24, 2025, at 1:20 p.m., during interview with CNS-D and RRN-A, CNS-D stated they ordered a new thermometer for the medication refrigerator. RRN-A stated they were going to find an inferred thermometer, take the temp of the medication refrigerator and if the medication refrigerator was out of range they would destroy</p>	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE		STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01880	Continued From page 28 the medication currently in the medication refrigerator. The manufactures instructions for latanoprost ophthalmic solution 0.005 % dated August 2011, indicated unopened latanoprost ophthalmic solution should be stored in a refrigerator with the temperature between 36 degrees F and 46 degrees F. The manufactures instructions for Novolog dated March 5, 2025, indicated Novolog should be stored in a refrigerator with the temperature between 36 degrees F and 46 degrees F. The licensee's Storage of Medication policy dated October 2024, indicated when secured storage of medication was necessary the registered nurse (RN) or licensed practical nurse (LPN) would identify where the medication would be store, how they would be secured or locked under proper temperature control and who has access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	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	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01890	<p>Continued From page 29</p> <p>by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were dated when opened for one of three residents (R8).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R8 was admitted to the licensee and began receiving assisted living services on January 29, 2024.</p> <p>R8's diagnoses included hypertension and dementia.</p> <p>R8's unsigned signed Service plan, dated effective as of May 30, 2025, indicated R8's services included monthly vitals, toileting, medication administration, grooming, housekeeping, bathing, dressing, and laundry.</p> <p>On June 23, 2025, at 12:08 p.m., the surveyor observed the contents of the facility medication cart, which contained one bottle of dorzolamide 2% (percent) and one bottle of Latanaprost0.005% for R8 with no open date/expired date label.</p> <p>On June 23, 2025, at 12:15 p.m., unlicensed personnel (ULP)-E stated, "The nurses didn't</p>	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37128	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/25/2025
NAME OF PROVIDER OR SUPPLIER HAVENWOOD OF MAPLE GROVE			STREET ADDRESS, CITY, STATE, ZIP CODE 18695 73RD 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
01890	<p>Continued From page 30</p> <p>write a date open, but I am sure it is not expired because the nurses check the carts each week and would have pulled it."</p> <p>On June 24, 2025, at 12:45 p.m., registered nurse (RN)-A stated, "All of the eye drops, liquids, creams, and whatnot should have a date open sticker put on when they are opened, and a written expiration date put on as well."</p> <p>The licensee's procedure titled 2.21 Eye Drops and Ointment indicated staff should check the expiration date on the medication container and the handwritten date indicating the open date of the medication prior to administering eye drops.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01890			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Havenwood of Maple Grove
18695 73rd Avenue North
Maple Grove, MN 55311
Hennepin County
Parcel:

Phone:

License Info

License: HFID 7128

Risk:
License:
Expires on:
CFPM: Michelle A. Otto
CFPM #: FM64407; Exp: 9/19/2027

Inspection Info

Report Number: F1047251043
Inspection Type: Full - Single
Date: 6/24/2025 Time: 10:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 2
Delivery:

! New Order: 3-500B Microbial Control: hot and cold holding

3-501.16A2 Priority Level: Priority 1 CFP#: 22

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: TEMPERATURE IN MEMORY CARE REFRIGERATOR WAS WARMER THAN 41F. TEMPERATURES RANGED FROM 45F TO 50F. FOOD WAS DISCARDED. FRIDGE SHOULD NOT BE USED UNTIL TEMPERATURE IS REMEDIED.

Comply By: 6/24/2025 Originally Issued On: 6/24/2025

New Order: 4-200 Equipment Design and Construction

4-204.112A Priority Level: Priority 3 CFP#: 36

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

COMMENT: DIGITAL DISPLAY BROKEN ON KITCHEN COOLER #2 AND NO INTERNAL THERMOMETER VISIBLE. CORRECTED ON SITE- THERMOMETER PLACED IN FRIDGE.

NO THERMOMETER LOCATED IN MEMORY CARE FRIDGE OR CARE SUITES FRIDGE.

Comply By: 6/24/2025 Originally Issued On: 6/24/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B Priority Level: Priority 2 CFP#: 48

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

COMMENT: DISK USED TO MEASURE DISHMACHINE TEMPERATURE IS NOT WORKING. REPAIR DISK OR REPLACE WITH SIMILAR DEVICE.

Comply By: 7/1/2025 Originally Issued On: 6/24/2025

New Order: 4-600 Cleaning Equipment and Utensils

4-602.13 Priority Level: Priority 3 CFP#: 49

MN Rule 4626.0855 Clean all non-food-contact surfaces of equipment at a frequency necessary to preclude accumulation of soil residues.

COMMENT: WAFFLE BATTER REMNANTS OBSERVED ON WAFFLE MAKERS IN STORAGE. CLEAN ALL EQUIPMENT BETWEEN USES.

Comply By: 6/24/2025 Originally Issued On: 6/24/2025

New Order: 5-200C Plumbing: Maintenance, fixture location

5-205.11AB *Priority Level: Priority 2 CFP#: 10*

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

COMMENT: KNIFE LOCATED IN KITCHEN HANDWASHING SINK. DISCUSSED NEED FOR HAND SINK TO ONLY BE USED FOR HANDWASHING

Comply By: 6/24/2025 Originally Issued On: 6/24/2025

Food & Beverage General Comment

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator T. Brown & A. Crews.

The establishment has a commercial kitchen. The facility also has a small memory care kitchenette, care suite kitchenette, and bistro area that primarily serves prepackaged items.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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 Metro District Office inspection report number F1047251043 from 6/24/2025

Michelle Otto
Operator


Holly Sievers,
Public Health Sanitarian 2
651-201-5946
holly.sievers@state.mn.us



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Page: 1

Establishment Info

Havenwood of Maple Grove
Maple Grove
County/Group: Hennepin County

Inspection Info

Report Number: F1047251043
Inspection Type: Full
Date: 6/24/2025
Time: 10:00 AM

Food Temperature: **Product/Item/Unit:** Fruit; **Temperature Process:** Cold-Holding

Location: Memory Care Fridge at 45 Degrees F.

Comment: Temps ranged from 45-50F

Violation Issued?: Yes

Food Temperature: **Product/Item/Unit:** Cut melon; **Temperature Process:** Cold-Holding

Location: Kitchen Cooler #3 at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Soup; **Temperature Process:** Hot-Holding

Location: Kitchen Cayenne Warmer at 158 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Tartar Sauce; **Temperature Process:** Cold-Holding

Location: Kitchen Cooler #2 at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Raw beef; **Temperature Process:** Cold-Holding

Location: Kitchen Cooler #1 at 36 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** Fruit; **Temperature Process:** Cold-Holding

Location: Care Suites Fridge at 37 Degrees F.

Comment:

Violation Issued?: No



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Havenwood of Maple Grove
Maple Grove
County/Group: Hennepin County

Inspection Info

Report Number: F1047251043
Inspection Type: Full
Date: 6/24/2025
Time: 10:00 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 165 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** 3-Compartment Sink

Location: Kitchen **Equal To** 200 PPM

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Kitchen **Equal To** 200 PPM

Comment:

Violation Issued?: No