Electronically delivered

June 8, 2022

Administrator
Cedar Crest Of Silver Lake
1401 Main Street West
Silver Lake, MN 55381

RE: Project Number(s) SL26903015

Dear Administrator:

On May 25, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on March 3, 2022. The follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the March 3, 2022 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on March 3, 2022, found not corrected at the time of the May 25, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0940-Contract Information-144g.50 Subd. 2

The details of the violations noted at the time of this follow-up evaluation completed on May 25, 2022 (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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

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

authorized in §144G.20.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in §144G.20.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

We urge you to review these orders carefully. If you have questions, please contact Casey DeVries at 651-201-5917.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	R 05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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 Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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 SL26903015-1 On May 24, 2022, through May 25, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on March 3, 2022. At the time of the survey, there were 39 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	R 05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action is required.	{0 480}		
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action is required.	{0 800}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	R 05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
{0 810}	Continued From page 2 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action is required.	{0 810}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	R 05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
{0 940}	Continued From page 3	{0 940}		
{0 940} SS=C	144G.50 Subd. 2 Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.	{0 940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	R 05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
{0 940}	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R2 and R3) with records reviewed. This had the potential to affect all 39 current residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Resident Agreement for Assisted Living was signed dated November 28, 2021. R2's Resident Agreement for Assisted Living was signed dated May 18, 2022. R3's Resident Agreement for Assisted Living was signed dated March 10, 2022. R1's, R2' and R3's Assisted Living Housing with Services Contracts lacked the following required content: -whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; -whether the facility has an agreement to provide housing support under section 256I.04 subdivision 2, paragraph (b); -whether there is a limit on the number of people	{0 940}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	R 05/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
{0 940}	Continued From page 5 residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -description of the rent requirement for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; and -contact information to obtain long-term care consulting services under section 256B.0911. On May 25, 2022, at approximately 1:33 p.m., owner/manager (OM)-G reviewed the assisted living contract with the surveyor and acknowledged the missing content. OM-G stated they would make the changes to the contract, "we have to." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	{0 940}		

Electronically Delivered
March 18, 2022

Administrator
Cedar Crest Of Silver Lake
1401 Main Street West
Silver Lake, MN 55381

RE: Project Number(s) SL26903015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 3, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2,

9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 the Department of Health within 15 calendar days of the correction order receipt date.

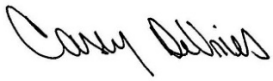
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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 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: SL26903015 On February 28, 2022, through March 3, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 38 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure representatives of the department of health had access to employee files to review for compliance. This had the potential to affect all 38 current residents 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 28, 2022, at approximately 10:50 a.m., registered nurse (RN)-A disclosed facility management was out of the country and would not be available during the survey. Further, RN-A stated because of management's absence, employee files, training records, competencies, background studies and TB (tuberculosis) information would	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 250	Continued From page 3 be inaccessible. RN-A added she understood these were needed to be reviewed by state to complete a survey and that usually someone from management was around. During the course of the survey from February 2, 2022, through March 3, 2022, the surveyor found employee records were not available. Most other documents including resident records, assessments and policies, were provided. During the exit conference on March 3, 2022, at approximately 1:40 p.m., the surveyor explained there would be a licensing order for failure to ensure the surveyor had full access to employee records to review to verify compliance. RN-A and licensed assisted living director (LALD)-M, who participated in the conference via phone, expressed understanding. A policy regarding surveyor access to records was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 250		
0 430 SS=B	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 430	Continued From page 4 living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) for two of five residents (R1, R3) with records reviewed. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), 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: R1 and R3 began receiving services under the assisted living licensure on August 1, 2021. R1 R1's service plan, revised July 23, 2021, indicated services included: medication administration, dependence for activities of daily	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 430	Continued From page 5 living (ADLs), assistance with grooming and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 4:30 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's evening medications. The signature page of R1's most recent service plan, noted above, indicated R1 acknowledged receipt of various documents (provided upon admission) including: Home Care Bill of Rights, complaint procedure, health care directive and others. There was no acknowledgment R1 received the uniform checklist disclosure of services (UDALSA) as required. R3 R3's service plan, dated November 30, 2021, indicated services included: medication administration, assistance with mobility in wheelchair, blood glucose monitoring, dependence with ADLs, assistance with denture and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 5:02 p.m., the surveyor observed unlicensed personnel (ULP)-C measure R3's blood glucose level and subsequently administer insulin to R3. The signature page of R3's most recent service plan, noted above, indicated R3 acknowledged receipt of various documents including: Home Care Bill of Rights, complaint procedure, health care directive and others. There was no acknowledgment R3 received the uniform checklist disclosure of services (UDALSA) as required. On March 3, 2022, at approximately 11:52 a.m. registered nurse (RN) verified dates of R1's and	0 430		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 430	Continued From page 6 R3's contracts and most recent service plan agreements. RN-A confirmed both residents' contracts and acknowledgements did not indicate they received the licensee's uniform checklist disclosure of services. RN-A said there were "inconsistencies" with the contract and service plans. The licensee's provided no policy regarding its uniform checklist disclosure of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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 7 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) 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). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated March 3, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center.	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 550	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post required information related to its grievance procedure and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all 38 residents, staff and visitors. 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: The licensee lacked a posting of its grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, there was no evidence of signage or contact information posted for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On February 28, 2022, at approximately 10:25 a.m., upon entrance into the facility, the surveyor observed no displayed or available information about the licensee's grievance procedure or posted information on how to report abuse to the MAARC. At approximately 11:23 a.m., the surveyor and resident coordinator (RC)-B	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 550	Continued From page 9 conducted a brief tour of the main entrance, foyer, and the area between the main dining room and offices and near the elevator; there was no signage or information regarding grievance procedures or reporting abuse displayed. RC-B confirmed this information was not posted. Registered nurse (RN)-B provided the licensee's policy book. The licensee lacked a policy that addressed required postings in the assisted living facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 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: Based on observation, interview and record review, the licensee failed to ensure individual abuse prevention plans included statements of specific measures to prevent abuse or minimize	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 630	Continued From page 10 identified vulnerabilities for four of four residents (R1, R2, R3 and R7) with records reviewed 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: R1 R1's diagnoses included depressive disorder, chronic kidney disease, renal failure, muscle weakness, unsteadiness of feet, retention of urine, dementia and generalized anxiety disorder. R1's service plan, revised July 23, 2021, indicated services included: medication administration, dependence for activities of daily living (ADLs), assistance with grooming and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 4:30 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's evening medications. R1's Individual Abuse Prevention Plan, dated April 20, 2021, identified the following vulnerabilities: unable to identify dangerous situation or deal with aggressive person; unable to care for self; impaired vision; wandering; unable to use phone or manage finances or pay bills; and unable to self-report abuse. R1's plan lacked statements of specific measures to be taken to minimize the	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 630	Continued From page 11 risk of abuse to R1 and other vulnerable adults. R2 R2's diagnoses included Alzheimer's dementia, hearing loss, chronic fatigue, gastric cancer and overactive bladder. R2's service plan, dated January 4, 2022, indicated services included: medication administration, assistance with ADLs, standby assistance or cueing with grooming and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 3:39 p.m., the surveyor observed ULP-C administer an as-needed medication to R2. R2's Individual Abuse Prevention Plan, dated October 29, 2021, identified the following vulnerabilities: unable to identify dangerous situation or deal with aggressive person; unable to care for self; lack of safety/self-preservation and wandering; refuses medications and history of non-compliance; impaired vision, hearing and speech; unable to use phone, manage finances, and unable to self-report abuse. R2's abuse prevention plan lacked statements of specific measures to be taken to minimize the risk of abuse to R2 and other vulnerable adults. R3 R3's diagnoses included type 2 diabetes, depression, restless leg syndrome, anxiety disorder, hypertension, non-compliance with medical treatment, glaucoma both eyes, hip pain and history of stroke. R3's service plan, dated November 30, 2021, indicated R3 received services including: medication administration, assistance with	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 630	Continued From page 12 mobility in wheelchair, blood glucose monitoring, dependence with ADLs, assistance with denture and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 5:02 p.m., the surveyor observed ULP-C measure R3's blood glucose level and subsequently administer insulin to R3. R3's Individual Abuse Prevention Plan, dated March 30, 2020, identified the following vulnerabilities: lack of understanding, likely to seek or cooperate in abusive situation, unable to identify dangerous situation or deal with aggressive person; unable to care for self; lack of safety/self-preservation; impaired vision; chronic pain, disability; impaired vision, hearing and speech; unable to use phone, manage finances, and unable to self-report abuse. R3's abuse prevention plan lacked statements of specific measures to be taken to minimize the risk of abuse to R3 and other vulnerable adults. R7 R7's diagnoses included dementia, anxiety disorder, chronic kidney disease, bipolar disorder, depression, hypertension, spinal stenosis low back pain. R7's service plan, dated December 29, 2021, indicated services included: medication administration, assistance with bathing, dressing and grooming and housekeeping and laundry services. On March 2, 2022, at approximately 8:26 a.m., the surveyor observed ULP-J transport R7 in a wheelchair from the dining room to R7's room, and then assist the resident with transfers and	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 630	Continued From page 13 toileting. R7's Individual Abuse Prevention Plan, dated December 29, 2021, identified the following vulnerabilities: unable to deal with aggressive person; lack of safety/self-preservation and wandering; impaired vision and hearing; unable to manage finances and unable to self-report abuse. R7's abuse prevention plan lacked statements of specific measures to be taken to minimize the risk of abuse to R7 and other vulnerable adults. On March 3, 2022, at approximately 11:41 a.m., registered nurse (RN)-A verified the residents' abuse prevention plans did not list specific interventions to reduce identified vulnerabilities. RN-A stated previously they used a different form to complete the assessments which listed resident-specific plans. RN-A confirmed all residents' individual abuse prevention plans lacked specific interventions and this was a system-wide issue. The licensee's Maltreatment-Communication, Prevention and Reporting policy, effective July 28, 2021, indicated the licensee prohibits the maltreatment of residents and provides individualized staff assessment, tools and resources to minimize the risk of maltreatment of a resident. The policy further indicated each resident shall have an individual abuse prevention plan including statements of specific measures to minimize risks of abuse for each vulnerable adult for whom services are provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 660	Continued From page 14	0 660		
0 660 SS=F	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: Based on interview and record review, the licensee failed to ensure the provider established and maintained 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) which included documentation of a completed TB Facility Risk Assessment. This had the potential to affect all residents and staff 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 660		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 660	Continued From page 15 or has the potential to affect a large portion or all of the residents). The licensee's current facility TB risk assessment, dated May 18, 2021, documented only that four counties, Meeker, Wright, McLeod and Sibley, had no reported TB cases. The assessment lacked the facility's risk classification and documented responsibility for its TB infection control program. An older assessment found in the TB infection control binder, dated April 4, 2014, identified responsible staff who were no longer employed by the licensee. On February 28, 2022, at approximately 2:59 p.m., registered nurse (RN)-A stated the assessment was typically completed using the worksheet and what was documented was "sparse." RN-A verified their current facility TB was not complete or up-to-date. The licensee's Tuberculosis & Staff Screening policy, effective May 16, 2014, indicated the licensee shall have a current infection control plan that included a person or team with supervisory responsibility for TB infection control. The policy also indicated the licensee shall complete a written community TB risk assessment and update periodically. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 680	Continued From page 16 (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 tenant 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 observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content. This had the potential to affect all 38 residents receiving services under the assisted living with dementia care license, staff and visitors in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 680	Continued From page 17 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 28, 2022, at approximately 11:15 a.m., the surveyor requested the licensee's emergency preparedness (EP) plan, including hazard assessments, policies and communication plan. Registered nurse (RN)-A stated there was a plan, but did not know if there was one document that included everything requested. RN-A directed the surveyor to emergency information located on the 2nd floor. At approximately 12:50 p.m., the surveyor toured the facility and noted on the second floor near the nursing station was a wall-mounted reference rack with various emergency responses. The display contained documents including procedures for fire, intruder, missing person, safety checks, death of a resident, severe weather and location of exit signs and emergency lighting. Prior to the survey's exit, staff provided the surveyor with a three-ringed binder to review, which included the following: A document "Mitigating Hazards at Cedar Crest of Silver Lake," a disaster plan policy, delegation of authority document, and several policies: disaster, fire, winter storms and severe weather. The licensee's plan lacked the following required content: -description of the population served by licensee; -process for emergency preparedness (EP)	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 680	Continued From page 18 cooperation with state and local EP officials/organizations; -procedure for tracking staff and residents; and -development of all policies/procedures, based on assessment; and additional policies for: -process for EP collaboration; -procedures for tracking staff and patients; -policies & procedures for handling medical documents; -roles under a waiver declared by the Secretary; and -development of a communication plan, including: -primary and alternate means for communication; -names and contact information; -emergency officials contact information; -methods for sharing information; -Sharing information on occupancy needs; -long term care family notifications; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. On March 3, 2022, at approximately 12:26 p.m., registered nurse (RN)-A stated she was aware managerial staff had worked on the disaster recovery plan. RN-A stated "we have some parts" of the plan, we practice drills, we do simulation, but acknowledged the plan as it is, may not be in full compliance. The licensee's Disaster Planning and Emergency Preparedness Plan policy, reviewed July 28, 2021, indicated the licensee will have in place a written plan of action to facilitate the management of clients [residents] care and services in response to emergencies that may disrupt their ability to provide care and/or services. The document addressed: hazard assessment;	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 680	Continued From page 19 development of policies; need to develop plans for sheltering in place and evacuation; staff training during orientation and annually. The document did not address posting of the emergency plan and also, did not fully align with the requirements in Appendix Z (the state-adopted guidelines for emergency preparedness). No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. 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	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 800	Continued From page 20 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). Findings include: On a facility tour with Director of Maintenance (DM)-N on March 1, 2022, between approximately 10:40 a.m. and 12:00 p.m., it was observed that the mechanical room in the memory care wing had extensive mold on the ceiling. Mold in the room housed by air distribution equipment has the potential to circulate mold throughout the resident care areas served by that equipment. This deficient condition was visually verified by (DM)-N accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 810	Continued From page 21 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to provide required employee training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 810	Continued From page 22 Findings include: A record review and interview were conducted on March 1, 2022, between approximately 10:00 a.m. and 10:40 a.m. with Director of Maintenance (DM)-N on the fire safety and evacuation plan and fire safety and evacuation training for the facility. Record review indicated that the fire safety and evacuation plan was not maintained and had provisions for fire safety but did not address evacuation. During interview, (DM)-N stated he was not aware of any provisions in the fire safety and evacuation plan for this requirement. Record review indicated that the fire safety and evacuation plan did not have employee actions to be taken in the event of a fire or similar emergency. During interview, (DM)-N stated he was not aware of any provisions in the fire safety and evacuation plan for this requirement. Record review indicated that the fire safety and evacuation plan did not have fire protection procedures necessary for residents. During interview, (DM)-N stated he was not aware of any provisions in the fire safety and evacuation plan for this requirement. Record review indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation in the procedures for resident movement, evacuation, or relocation during a fire or similar emergency. During interview, (DM)-N stated he was not aware of any provisions in the fire safety and evacuation plan for this requirement.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 810	Continued From page 23 Record review indicated that employees did not receive training twice per year after initial hire on the facility fire safety and evacuation plan. During interview, (DM)-N stated that the licensee provides training on fire safety twice per year but could not verify if any training was provided on evacuation. (DM)-N was not able to provide documentation or a policy to verify this. Record review indicated that that the licensee did not have documentation indicating that evacuation drills had been conducted every other month as required. During interview, (DM)-N stated that the licensee had not conducted any evacuation drills in the five years he had been employed with the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 910 SS=C	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by:	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 910	Continued From page 24 Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of four residents (R1, R2 and R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's service plan, revised July 23, 2021, indicated services included: medication administration, dependence for activities of daily living (ADLs), assistance with grooming and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 4:30 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's evening medications. R1's Elderly Housing with Services Contract, signed by R1's power of attorney and dated February 28, 2017, lacked the license number of the facility. R2 R2's service plan, dated January 4, 2022, indicated services included: medication administration, assistance with ADLs, standby assistance or cueing with grooming and nail care and housekeeping and laundry services.	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 910	Continued From page 25 On February 28, 2022, at approximately 3:39 p.m., the surveyor observed ULP-C administer medication to R2. R2's Elderly Housing with Services Contract, signed by R2 on October 12, 2020, lacked the license number of the facility. R3 R3's service plan, dated November 30, 2021, indicated services included: medication administration, assistance with mobility in wheelchair, blood glucose monitoring, dependence with ADLs, assistance with denture and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 5:02 p.m., the surveyor observed ULP-C measure R3's blood glucose level and subsequently administer insulin to R3. R3's Elderly Housing with Services Contract was signed by R3 on February 7, 2017. R3's contract lacked the legal name and license number of the facility, and also the name, telephone number and physical mailing address of the facility. On March 3, 2022, at approximately 11:52 a.m., registered nurse (RN)-A verified R1's, R2's and R3's signed contracts contained outdated language and also R3's contract had an address on the contract of a facility site no longer used by the licensee. RN-A acknowledged the inconsistencies in the contracts and deferred to the owner in charge of contracts, adding that there may be resident documents that are not part of the chart that we don't have access to. RN-A also said she did not know if there were	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 910	Continued From page 26 issues with more resident contracts. A policy regarding resident assisted living contracts was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 920	Continued From page 27 by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for three of four residents (R1, R2 and R3) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's, R2's and R3's contracts lacked disclosure of the facility's ability to provide specialized diets. R1 R1's service plan, revised July 23, 2021, indicated services included: medication administration, dependence for activities of daily living (ADLs), assistance with grooming and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 4:30 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's evening medications. R1's Elderly Housing with Services Contract, signed by R1's power of attorney February 28, 2017, lacked content listed above. R2 R2's service plan, dated January 4, 2022, indicated services included: medication	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 920	Continued From page 28 administration, assistance with ADLs, standby assistance or cueing with grooming and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 3:39 p.m., the surveyor observed ULP-C administer medication to R2. R2's Elderly Housing with Services Contract, signed by R2 on October 12, 2020, lacked content listed above. R3 R3's service plan, dated November 30, 2021, indicated services included: medication administration, assistance with mobility in wheelchair, blood glucose monitoring, dependence with ADLs, assistance with denture and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 5:02 p.m., the surveyor observed ULP-C measure R3's blood glucose level and subsequently administer insulin to R3. R3's Elderly Housing with Services Contract, signed by R3 on February 7, 2017, lacked content listed above. On March 3, 2022, at approximately 11:52 a.m., registered nurse (RN)-A acknowledged the inconsistencies in R1's, R2's and R3's contracts and deferred to the owner in charge of contracts, adding that there may be resident documents that are not part of the chart that we don't have access to. RN-A also said she did not know if there were issues with more resident contracts. A policy regarding resident assisted living	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 920	Continued From page 29 contracts was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for four of four residents (R1, R2, R3 and R7) with records reviewed.	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 930	Continued From page 30 This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's, R2's, R3's and R7's contracts lacked the following content: -the right under section 144G.54 to appeal the termination of an assisted living contract; -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for transfer; -contact information for the Ombudsman for Mental Health and Developmental Disabilities (not missing from R7's contract); and -the residents' right to obtain services from an unaffiliated service provider. R1 R1's service plan, revised July 23, 2021, indicated services included: medication administration, dependence for activities of daily living (ADLs), assistance with grooming and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 4:30 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's evening medications. R1's Elderly Housing with Services Contract, signed by R1's power of attorney February 28,	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 930	Continued From page 31 2017, lacked content listed above. R2 R2's service plan, dated January 4, 2022, indicated services included: medication administration, assistance with ADLs, standby assistance or cueing with grooming and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 3:39 p.m., the surveyor observed ULP-C administer medication to R2. R2's Elderly Housing with Services Contract, signed by R2 on October 12, 2020, lacked content listed above. R3 R3's service plan, dated November 30, 2021, indicated services included: medication administration, assistance with mobility in wheelchair, blood glucose monitoring, dependence with ADLs, assistance with denture and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 5:02 p.m., the surveyor observed ULP-C measure R3's blood glucose level and subsequently administer insulin to R3. R3's Elderly Housing with Services Contract, signed by R3 on February 7, 2017, lacked content listed above. R7 R7's service plan, dated December 29, 2021, indicated services included: medication administration, assistance with bathing, dressing and grooming and housekeeping and laundry	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 930	Continued From page 32 services. On March 2, 2022, at approximately 8:26 a.m., the surveyor observed ULP-J transport R7 in a wheelchair from the dining room to R7's room, and assist R7 with transfers and toileting. R7's Elderly Housing with Services Contract, signed by R7's representative on December 29, 2021, lacked content listed above. On March 3, 2022, at approximately 11:52 a.m., registered nurse (RN)-A acknowledged the inconsistencies in the contracts and deferred to the owner in charge of contracts, adding that there may be resident documents that are not part of the chart that we don't have access to. RN-A also said she did not know if there were issues with more resident contracts. A policy regarding resident assisted living contracts was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 940	Continued From page 33 provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written assisted living contract with the required content for four of four residents (R1, R2, R3 and R7) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 940	Continued From page 34 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's, R2's, R3's and R7's assisted living contracts lacked the following content: -a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: -whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); -whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; -whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; -a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; -a statement that residents may be eligible for assistance with rent through the housing support program; -a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; and -the contact information to obtain long-term care consulting services under section 256B.0911. R1	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 940	Continued From page 35 R1's service plan, revised July 23, 2021, indicated services included: medication administration, dependence for activities of daily living (ADLs), assistance with grooming and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 4:30 p.m., the surveyor observed unlicensed personnel (ULP)-C administer R1's evening medications. R1's Elderly Housing with Services Contract, signed by R1's power of attorney February 28, 2017, lacked content listed above. R2 R2's service plan, dated January 4, 2022, indicated services included: medication administration, assistance with ADLs, standby assistance or cueing with grooming and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 3:39 p.m., the surveyor observed ULP-C administer medication to R2. R2's Elderly Housing with Services Contract, signed by R2 on October 12, 2020, lacked content listed above. R3 R3's service plan, dated November 30, 2021, indicated services included: medication administration, assistance with mobility in wheelchair, blood glucose monitoring, dependence with ADLs, assistance with denture and nail care and housekeeping and laundry services. On February 28, 2022, at approximately 5:02	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 940	Continued From page 36 p.m., the surveyor observed ULP-C measure R3's blood glucose level and subsequently administer insulin to R3. R3's Elderly Housing with Services Contract, signed by R3 on February 7, 2017, lacked content listed above. R7 R7's service plan, dated December 29, 2021, indicated services included: medication administration, assistance with bathing, dressing and grooming and housekeeping and laundry services. On March 2, 2022, at approximately 8:26 a.m., the surveyor observed ULP-J transport R7 in a wheelchair from the dining room to R7's room, and assist R7 with transfers and toileting. R7's Elderly Housing with Services Contract, signed by R7's representative on December 29, 2021, lacked content listed above. On March 3, 2022, at approximately 11:52 a.m., registered nurse (RN)-A acknowledged the inconsistencies in the contracts and deferred to the owner in charge of contracts, adding that there may be resident documents that are not part of the chart that we don't have access to. RN-A also said she did not know if there were issues with more resident contracts. A policy regarding resident assisted living contracts was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 950 SS=E	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative for three of three residents (R1, R2 and R3) with records reviewed.	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 950	Continued From page 38 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: R1 R1's service plan, revised July 23, 2021, indicated R1's services included medication administration, dependence for activities of daily living (ADLs), assistance with grooming and nail care and housekeeping and laundry services. R1's record did not contain a notice with the required statutory language for R1 to identify a designated representative or documentation that R1 declined to name a designated representative. R2 R2's service plan, dated January 4, 2022, indicated R2's services included medication administration, assistance with ADLs, standby assistance or cueing with grooming and nail care and housekeeping and laundry services. R2's record did not contain a notice with the required statutory language for R2 to identify a designated representative or documentation that R2 declined to name a designated representative. R3 R3's service plan, dated November 30, 2021, indicated R3's services included medication	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
0 950	Continued From page 39 administration, assistance with mobility in wheelchair, blood glucose monitoring, dependence with ADLs, assistance with denture and nail care and housekeeping and laundry services. R3's record did not contain a notice with the required statutory language for R3 to identify a designated representative or documentation that R3 declined to name a designated representative. On March 3, 2022, at approximately 12:01 p.m., registered nurse (RN)-A verified R1's, R2's and R3's records lacked documentation they had designated or declined to name a representative. RN-A verified documentation was found in other residents' charts, but not these. RN-A acknowledged the inconsistencies in the contracts and deferred to the owner in charge of contracts, adding that there may be resident documents that are not part of the chart that we don't have access to. The licensee lacked a policy regarding the resident's right to name or decline to name a designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01760 SS=F	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	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
01760	Continued From page 40	01760		

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:
Based on observation, interview and record review, the licensee failed to ensure parameters were documented in the medication administration record (MAR) for the appropriate dose to administer an as-needed (PRN) pain medication, for one of one resident (R2) observed during a medication pass. This had potential to affect all residents with routine standing orders for common pain medication. In addition, the licensee failed to ensure the pharmacy label on a medication matched the medication administration record (MAR) for one of one resident (R3) observed during insulin administration.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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:

LACK OF DOSAGE PARAMETERS FOR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
01760	Continued From page 41 AS-NEEDED PAIN MEDICATION R2's diagnoses included Alzheimer's dementia, hearing loss, chronic fatigue, gastric cancer and overactive bladder. R2's service plan, dated January 4, 2022, indicated services included: medication administration, assistance with ADLs, standby assistance or cueing with grooming and nail care and housekeeping and laundry services. R2's medication management plan, dated January 4, 2022, indicated documentation of specific client instructions relating to the administration of medications was located on the resident MAR. R2's prescriber's orders, dated October 8, 2021, included daily multi vitamin. R2 also had routine standing orders (RSO) dated November 18, 2021, which included Tylenol. The order directed to give Tylenol 325 mg, 1-2 tabs by mouth every 4 hours as needed for discomfort or temperature above 101.0. On February 28, 2022, at approximately 3:39 p.m., R2 expressed discomfort and requested pain medication. The surveyor observed unlicensed personnel (ULP)-C review R2's MAR and inform R2 she could give her one or two tablets of Tylenol. R2 stated she would take one, and then if that didn't help, would take another later. ULP-C told R2 she would have to wait four hours before having another dose. R2 said she might as well take both pills now. ULP-C administered two tablets of 325 mg (milligrams) of Tylenol to R2. At 3:41 p.m., ULP-C verified R2's order did not	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
01760	Continued From page 42	01760		

specify when to give one tablet and when to give two tablets. ULP-C said if a resident had a narcotic ordered, they try to use a non-narcotic first or ask for some kind of pain-scale rating. ULP-C verified no specific dosing directions were provided in the routine standing order for Tylenol.

On March 3, 2022, registered nurse (RN)-A verified the Tylenol orders for R2 did not have parameters for administration. RN-A stated they were going to make changes to the RSO form and confirmed the RSO order form was used for all residents.

The licensee's PRN (as needed) Medication Administration Policy, revised December 10, 2021, indicated medications always need to be administered according the "6 rights" which included "right dose" (i.e. how many milligrams, drops). The policy also indicated any special instruction should be in place.

PHARMACY LABEL NOT MATCHING THE MAR

R3's diagnoses included type 2 diabetes, depression, restless leg syndrome, anxiety disorder, hypertension, non-compliance with medical treatment, glaucoma both eyes, hip pain and history of stroke.

R3's service plan, dated November 30, 2021, indicated R3 received services including: medication administration, assistance with mobility in wheelchair, blood glucose monitoring, dependence with ADLs, assistance with denture and nail care and housekeeping and laundry services.

R3's medication management plan, dated February 18, 2022, indicated R3 received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
01760	Continued From page 43 medication administration, a task delegated to unlicensed personnel, and specific instruction related to administration were locate on the MAR. R3's prescriber's orders, dated February 8, 2022, included insulin Novolog Flexpen, inject 14 units before meals 8:00 A.M., 12:00 P.M. and 16 units before meal 18:00 (6:00 p.m.) On February 28, 2022, at approximately 5:02 p.m., the surveyor observed ULP-C measure R3's blood glucose level and subsequently prepare to administer insulin to R3. ULP-C completed checks on the MAR, primed the insulin pen and dialed 16 units and showed the dose to the surveyor and that it matched the order in the MAR. However, the pharmacy label on R3's insulin pen (which directed to administer 14 units twice a day) did not match the order for the 6:00 p.m., dose. ULP-C administered 16 units of insulin to R3. ULP-C verified the dose administered to R3, and also confirmed the pharmacy label did not match the order in the MAR. ULP-C also confirmed there was no "change of direction" label on the insulin pen, which ULP-C stated there should have been, "like for all medications" if there had been a change in the order by the doctor. On March 3, 2022, at approximately 11:49 a.m., RN-A said R3's order was for 14 units at 8 a.m. and noon, but was 16 units for the evening dose, and acknowledged the order on the label didn't match the system. RN-A said there were issues with the interface between the electronic system and the pharmacy, and unfortunately the last part of the order was not printed on the label. RN-A stated the insulin order must match what is on the pen.	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
01760	Continued From page 44 The licensee's PRN (as needed) Medication Administration Policy, revised December 10, 2021, indicated in the procedure, under #2: The directions (for dispensing medication) on the label and the MAR should be the same. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
02110	Continued From page 45 efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. This had the potential to affect all residents in the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee was licensed as an Assisted Living with Dementia Care facility. Review of the licensee's policies on October 19, 2021, indicated the licensee lacked the following required policies and procedures: -philosophy of how services are provided based upon the assisted living facility license's values,	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
02110	Continued From page 46	02110		

mission, and promotion of person-centered care and how the philosophy shall be implemented;
- evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;
-wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;
- medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;
-description of life enrichment programs and how activities are implemented;
-descriptions of family support program and efforts to keep the family engaged;
- limiting the use of public address and intercom systems for emergencies and evacuation drills only;
- transportation coordination and assistance to and from outside medical appointments; and
- safekeeping of residents' possessions.

On March 2, 2022, at approximately 3:11 p.m., activities director/unlicensed personnel (ULP)-C and activities director/ULP-E stated their roles were to assist with and lead residents to participate in activities. ULP-C said she was not aware of new policy rules for dementia or that residents were to be given policies when they came into the dementia unit.

On March 3, 2022, at approximately 11:29 a.m., registered nurse (RN)-A stated they had a number of the required policies, but not all. RN-A did not know if the policies were presented to a resident upon admission and did not have a packet available that the licensee would provide to a prospective resident. RN-A stated they would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
02110	Continued From page 47 have to enhance or develop policies to get into compliance and also this would be a widespread issue. The licensee's Alzheimer's Disease and Related Disorders - Training and Notification policy revised July 28, 2021, addressed only staff training requirements. The document lacked mention of the above policies or indication they would be provided to residents/representatives at move in as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
02170	Continued From page 48 plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have an evaluation for activities with all required content or to develop activity plans based on the assessments for two of two residents (R2, R7) who resided in the secured dementia care unit. 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: The licensee had a current assisted living with dementia care license.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
02170	Continued From page 49 R2 R2's diagnoses included Alzheimer's dementia, hearing loss, chronic fatigue, gastric cancer and overactive bladder. R2's General Information Form and initial activity assessment, dated October 13, 2020, and November 13, 2020, respectively, included assessment for past and current interests, past jobs, assessment for ability to read and write, religious preferences and past alcohol and tobacco use. R2's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following: - current abilities and skills; - emotional and social needs and patterns; - physical abilities and limitations; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions. In addition, R2's record lacked the development of an individualized activity plan. R7 R7's diagnoses included dementia, anxiety disorder, chronic kidney disease, bipolar disorder, depression, hypertension, spinal stenosis low back pain. R7's General Information Form dated December 29, 2021, indicated R7 had activities and leisure likes including talking, crafts/arts, music and cards. A note written on the form indicated R7 loved activities and to keep busy and wanted to	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
02170	Continued From page 50	02170		

attend all activities. R7's record lacked any additional activity assessment.

R7's record lacked evidence that the resident had been evaluated for activities according to the licensing rules of the facility, to include the following:
- past and current interests;
- current abilities and skills;
- emotional and social needs and patterns;
- physical abilities and limitations;
- adaptations necessary for the resident to participate; and
- identification of activities for behavioral interventions.

In addition, R7's record lacked the development of an individualized activity plan.

On March 2, 2022, at approximately 3:11 p.m., activities director/unlicensed personnel (ULP)-C and activities director/ULP-E stated their roles were to assist with and lead residents to participate in activities. ULP-C stated she was not aware of a formal plan for residents, other than the activity calendars that listed the events and activities schedule. ULP-C stated she was not aware of any new changes with activities since the new assisted living license last summer.

On March 3, 2022, at approximately 11:29 a.m. registered nurse (RN) stated she really could not speak about activities.

The licensee's Alzheimer's Disease and Related Disorders - Training and Notification policy revised July 28, 2021, addressed only staff training requirements. The licensee lacked a policy regarding resident assessment with required content for activities and further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
02170	Continued From page 51 development of an activity plan based on the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post a required notice with statutory language at the main entry of the facility to disclose electronic monitoring activity. This had the potential to affect all 38 current residents, staff and any visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), 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).	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26903	A. BUILDING: _____ B. WING _____	03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST OF SILVER LAKE	1401 MAIN STREET WEST SILVER LAKE, MN 55381

(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
03090	Continued From page 52 Findings include: On February 28, 2022, at approximately 10:23 a.m., the surveyor entered the facility and observed no signage posted at the entrance or areas accessible to all regarding electronic monitoring. On March 3, 2022, at approximately 11:45 a.m., during a tour of the facility, resident coordinator (RC)-B stated there were working cameras in the common areas in the building. RC-B verified the licensee did not have signage posted at the facility entrance or in the large hallway between the offices and dining area regarding electronic monitoring. RC-B said residents were provided information about electronic monitoring in their admission packet. Registered nurse (RN)-B provided the licensee's policy book. The licensee lacked a policy regarding electronic monitoring and posting the required notice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/03/22*
Time: 10:50:33
Report: 1020221024

Food and Beverage Establishment Inspection Report

Location:
Cedar Crest Of Silver Lake
1401 Main Street West
Silver Lake, MN55381
Mc Leod County, 43

Establishment Info:
ID #: 0038041
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3203276577
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-800 Highly Susceptible Populations

3-801.11B ** Priority 1 **

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

BATCHES OF UNPASTEURIZED EGGS ARE BEING COMBINED AND SERVED TO MULTIPLE RESIDENTS FOR SCRAMBLED EGGS; USE PASTEURIZED EGGS. REFER TO MN RULE 4626.0447 PART F. DISCUSSED WITH PERSON IN CHARGE. PERSON IN CHARGE STATED EGGS WILL BE SWITCHED.

Comply By: 03/04/22

4-500 Equipment Maintenance and Operation

4-501.112A ** Priority 2 **

MN Rule 4626.0795A Maintain the temperature at the manifold of the hot water sanitizing rinse at a maximum temperature of 194 degrees F (90 degrees C) and no less than 165 degrees F (74 degrees C) for a single tank, stationary rack, single temperature machine or 180 degrees F (82 degrees C) for all other machines.

RINSE TEMPERATURE GAUGE NON-FUNCTIONAL; REPAIR. DISCUSSED WITH PERSON IN CHARGE.

Comply By: 03/31/22

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

MOLD GROWTH ON THE WALK-IN COOLER DOOR GASKET.

Comply By: 03/07/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

Wash Temperature Gauge: = at 155 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Final Rinse Temperature Ga: = at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: Yes

Utensil Surface Temperatur: = at 165 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: CHICKEN NOODLE SOUP - UPRIGHT COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: HAM AND CHEESE PASTA - UPRIGHT COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: BUTTER - WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - WALK-IN FREEZER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	1

GENERAL COMMENTS:

DISCUSSED CURRENT COVID-19 AND EMPLOYEE ILLNESS POLICIES AND PROCEDURES. EMPLOYEE ILLNESS LOG USED ON-SITE. ILLNESS REPORTING REQUIREMENTS FACT SHEET PROVIDED WITH THE REPORT.

DISCUSSED ANY COOLING AND RE-HEATING PROCEDURES. TEMPERATURE AND TIME

Food and Beverage Establishment Inspection Report

REQUIREMENTS FACT SHEET PROVIDED WITH THE REPORT.

DISCUSSED MAJOR FOOD ALLERGEN POLICIES AND PROCEDURES. BOOK KEPT ON-SITE WITH ALL RESIDENT ALLERGENS.

DISCUSSED SANITIZING PROCEDURES.

DISCUSSED UNPASTEURIZED EGGS AND USAGE. PROVIDED FACT SHEET ON HIGHLY SUSCEPTIBLE POPULATIONS.

VOMIT AND DIARRHEA CLEANUP PROCEDURE EXAMPLE PROVIDED WITH THE REPORT.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1020221024 of 03/03/22.

Certified Food Protection Manager: John H. Beck

Certification Number: FM24518 Expires: 03/31/25

Inspection report reviewed with person in charge and emailed.

Signed: Report emailed
Establishment Representative

Signed: Ashley B
Ashley B

651-201-4500

Report #: 1020221024

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	2	Date	03/03/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:50:33
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Cedar Crest Of Silver Lake	1401 Main Street West	Silver Lake, MN	55381	3203276577

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038041		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1 IN OUT	PIC knowledgeable; duties & oversight		
2 IN OUT N/A	Certified food protection manager, duties		
Employee Health			
3 IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4 IN OUT	Proper use of reporting, restriction & exclusion		
5 IN OUT	Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices			
6 IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7 IN OUT N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands			
8 IN OUT N/O	Hands clean & properly washed		
9 IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10 IN OUT	Adequate handwashing sinks supplied/accessible		
Approved Source			
11 IN OUT	Food obtained from approved source		
12 IN OUT N/A N/O	Food received at proper temperature		
13 IN OUT	Food in good condition, safe, & unadulterated		
14 IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination			
15 IN OUT N/A N/O	Food separated and protected		
16 IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17 IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status		COS	R
Time/Temperature Control for Safety			
18 IN OUT N/A N/O	Proper cooking time & temperature		
19 IN OUT N/A N/O	Proper reheating procedures for hot holding		
20 IN OUT N/A N/O	Proper cooling time & temperature		
21 IN OUT N/A N/O	Proper hot holding temperatures		
22 IN OUT N/A	Proper cold holding temperatures		
23 IN OUT N/A N/O	Proper date marking & disposition		
24 IN OUT N/A N/O	Time as a public health control: procedures & records		
Consumer Advisory			
25 IN OUT N/A	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations			
26 IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances			
27 IN OUT N/A	Food additives: approved & properly used		
28 IN OUT	Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures			
29 IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49	X	Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) Report emailed **Date:** 03/03/22

Inspector (Signature)