



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 10, 2023

Licensee
Cedar Creek Senior Living
19131 Taylor Street
East Bethel, MN 55011

RE: Project Number(s) SL36636015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 28, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

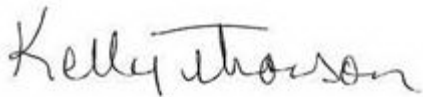
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in dark ink that reads "Kelly Thorson". The signature is written in a cursive, flowing style.

Kelly Thorsen, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 651-281-9796

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/28/2023
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 19131 TAYLOR STREET EAST BETHEL, MN 55011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36636015 On June 26, 2023, through June 28, 2023, 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 71 active residents; 70 receiving services under the 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.	
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a	01060		

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/28/2023
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 19131 TAYLOR STREET EAST BETHEL, MN 55011		
(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
01060	Continued From page 1 resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/28/2023
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 19131 TAYLOR STREET EAST BETHEL, MN 55011		
(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
01060	Continued From page 2 in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R4) 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) 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: R4 admitted for services on July 21, 2022. R4's Service Addendum dated May 10, 2023, indicated R4 received services for medication assist, bathing, dressing, transfer assist, toileting, turning and repositioning, meal reminders, bed making, laundry, and housekeeping. R4's Progress Notes dated January 1, 2023, indicated the licensee sent R4 to mercy hospital January 1, 2023, to be evaluated in the hospital related to pneumonia. R4 had returned to licensee via mercy hospital transport on January 1, 2023. R4's record lacked a written notice delivered to the resident or designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/28/2023
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 19131 TAYLOR STREET EAST BETHEL, MN 55011		
(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
01060	Continued From page 3 location to which the resident has been relocated and any new service provider; - contact information for OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On June 27, 2023, at 9:38 a.m., clinical nurse supervisor (CNS)-B and registered nurse (RN)-C verified R4's record lacked a written emergency relocation notice. CNS-B stated they were unaware of the requirement and have not issued notices upon resident emergency relocation to any licensee residents. CNS-B stated licensee had contacted the OOLTC on any resident who had a hospitalization longer than four days and they did not notify the ombudsman as R4 had a hospital stay of one night. The licensee's Service Plan policy dated June 2017, indicated in an event of an emergency relocation, the facility must provide a written notice to resident, the resident's legal representative and designated representative that contains, at a minimum -the reason for relocation; -the name and contact information for the location of which the resident has been relocated and any new services provider; -contact information for the office of ombudsman for long-term care and the office of ombudsman for mental health and developmental disabilities; -if known and applicable, the approximate date or	01060		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/28/2023
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 19131 TAYLOR STREET EAST BETHEL, MN 55011		
(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
01060	Continued From page 4 range of dates within which the resident is expected to return to facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit appeal. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/28/2023
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 19131 TAYLOR STREET EAST BETHEL, MN 55011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 5 prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed an ongoing reassessment and monitoring on or before day 90 for four of five residents (R1, R2, R3, R5). 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 the residents). The findings include: On June 26, 2023, at 10:30 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated a registered nurse completed assessments pre-admission, within 14 days, every 90 days, and with changes in condition. R1 began receiving services on May 26, 2021. R1's record indicated 90-day comprehensive nursing assessments were completed on July 27, 2022 and January 19, 2023, 177 days apart, and April 27, 2023, 99 days apart. R2 began receiving services on April 12, 2021. R2's record indicated 90-day comprehensive	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/28/2023
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 19131 TAYLOR STREET EAST BETHEL, MN 55011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 6 nursing assessments were completed on August 1, 2022 and January 16, 2023, 169 days apart, and May 4, 2023, 109 days apart. R3 began receiving services on April 28, 2021. R3's record indicated 90-day comprehensive nursing assessments were completed on August 1, 2022 and December 23, 2023, 145 days apart, and April 19, 2023, 118 days apart. R5 began receiving services on November 2, 2021. R5's record indicated 90-day comprehensive nursing assessments were completed on July 31, 2022 and February 28, 2023, 212 days apart, and June 2, 2023, 94 days apart. On June 27, 2023, at 3:00 p.m., clinical nurse supervisor (CNS)-B stated the facility was going through a transition of nurses for a period of time plus they changed their electronic system. CNS-B further stated the know assessments are supposed to be done at 90 days and they now have a tracking system in place to ensure they do not get behind again. The licensee's Service Plan policy revised April 2023, indicated a registered nurse will review and monitor all health related services provided to the resident within 14 days of admission and at least every 90 days. The registered nurse will complete an initial individualized assessment within 14 days after initiation of services and if there is a change in resident's condition.. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/28/2023
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 19131 TAYLOR STREET EAST BETHEL, MN 55011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 7 (21) days	01620		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 admitted for services on November 2, 2021. R5's Service Addendum dated November 11, 2022, indicated R5 received services for medication assist, bathing, dressing, transfer assist, toileting, safety checks, reminders, bed making, laundry, and housekeeping.	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/28/2023
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 19131 TAYLOR STREET EAST BETHEL, MN 55011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 8 On June 27, 2023, at 7:49 a.m., the surveyor observed unlicensed personnel (ULP)-E provide morning medication administration for R5. ULP-E reviewed the medication administration record followed the order to provide arthricream 10% topically four times a day as needed for arthritis pain. ULP-E applied gloves and applied aspercreme to resident shoulders and back. On June 27, 2023, at 7:59 a.m., the surveyor observed a bottle of aspercreme unlabeled in the locked cabinet in R5's room and an empty aspercreme tube unlabeled on R5's nightstand. ULP-E verified the unlabeled medication and stated R5's daughter provided the aspercreme as R5 was able to self-administer the cream. On June 27, 2023, at 9:38 a.m. clinical nurse supervisor (CNS)-B verified R5 did not have a label on the aspercreme stated R5 had a provider's order to have at bedside. CNS-B stated if a resident had a provider order to self-administer their medication the medication did not need a label. On June 27, 2023, at 10:04 a.m. surveyor reviewed R5's order information dated May 6, 2022, indicated aspercreme 10%; applied to affected area four times a day as needed for arthritis pain white crème liniment camphor turpentine four times a day as needed to affected area. Resident may have both in apartment. Ok to self-administer unless resident is not able to do on his own. The licensee's Medication and Treatments policy dated March 2018, indicated the medication administration record should be compared to the label on the medication upon medication	01890		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36636	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/28/2023
NAME OF PROVIDER OR SUPPLIER CEDAR CREEK SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 19131 TAYLOR STREET EAST BETHEL, MN 55011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 9 administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		



Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: 06/27/23
Time: 12:15:47
Report: 1029231144

Food and Beverage Establishment Inspection Report

Page 1

Location:

Cedar Creek Senior Living
19131 Taylor Street
East Bethel, MN55011
Anoka County, 02

Establishment Info:

ID #: 0038053
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633925443
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.

No NEW orders were issued during this inspection.

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	0	0

Cedar Creek Senior Living's food services are provided by Cura Hospitality LLC, a 3rd-party contractor. Cura Hospitality LLC is licensed through Anoka County under license number FB-004780-2023.

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 1029231144 of 06/27/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____/____/____

Signed: _____

Establishment Representative

Signed: _____

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us