Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

April 28, 2026

Licensee
Cedar Cove Assisted Living
21596 Cedar Lake Road
Sauk Centre, MN 56378

RE: License Number 424172
Health Facility Identification Number (HFID) 28803
Project Number(s) SL28803016

Dear Licensee:

On November 19, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed February 12, 2025. The follow-up survey found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective **April 20, 2026**.

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

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

Furthermore, the follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the 11/19/2025 initial survey.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a), state correction orders issued pursuant to the last survey completed on November 19, 2025, found not corrected at the time of the follow-up survey follow-up survey and/or subject to a penalty assessment are as follows:

1370-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (a) - $500.00
1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (b) - $500.00
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) - $500.00

The details of the violations noted at the time of this follow-up survey completed on November 19, 2025 (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, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per 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).

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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that

has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	R 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL28803016-2 On November 18, 2025, through November 19, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on June 5, 2025. At the time of the survey, there were four (4) residents receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}		

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

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls;	{01370}		

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{01370}	Continued From page 3 (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of three unlicensed personnel ((ULP)-D). 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:	{01370}		

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{01370}	Continued From page 4 ULP-D was hired on March 25, 2020, to provide direct care services to residents of the facility. ULP-D's employee record lacked documented evidence of the following required training/competency testing: - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and assistance with dressing and toileting; - training on the prevention of falls for providers working with elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional- understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On November 18, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated ULP-D had been a long-time employee and believed the licensee had completed training and competency testing prior to CNS-A's employment with the licensee. CNS-A stated the licensee had completed the required training and testing for all recent new hires, but no documentation ULP-D had been trained and competency tested was	{01370}		

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{01370}	Continued From page 5 located in ULP-D's record. CNS-A stated licensee had implemented a new training form for the recently hired staff and would use the new training form for ULP-D to ensure compliance with requirements. The licensee's Training and Competency Evaluation of Unlicensed Staff policy dated September 15, 2022, indicated all staff would meet all orientation and training requirements and be determined competent to perform all tasks by the registered nurse or other licensed health professional before they may provide any services to residents. No further information provided.	{01370}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced	{01380}		

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{01380}	Continued From page 6 by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of three unlicensed personnel ((ULP)-D). 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: ULP-D was hired on March 25, 2020, to provide direct care services to residents of the facility. ULP-D's employee record lacked documented evidence of the following required training/competency testing: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motion and positioning; - administering treatments as required. On November 18, 2025, at 1:30 p.m., clinical	{01380}		

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{01380}	Continued From page 7 nurse supervisor (CNS)-A stated ULP-D had been a long-time employee and believed the licensee had completed training and competency testing prior to CNS-A's employment with the licensee. CNS-A stated the licensee had completed the required training and testing for all recent new hires, but no documentation ULP-D had been trained and competency tested was located in ULP-D's record. CNS-A stated licensee had implemented a new training form for the recently hired staff and would use the new training form for ULP-D to ensure compliance with requirements. The licensee's Training and Competency Evaluation of Unlicensed Staff policy dated September 15, 2022, indicated all staff would meet all orientation and training requirements and be determined competent to perform all tasks by the registered nurse or other licensed health professional before they may provide any services to residents. No further information provided.	{01380}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic	{01620}		

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{01620}	Continued From page 8 distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) 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 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:	{01620}		

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{01620}	Continued From page 9 Based on interview and record review, the licensee failed to ensure all areas of the uniform assessment tool as required per Minnesota Administrative Rule 4659.0150, were addressed for three of three residents (R1, R3, and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on March 4, 2021. R1's Skilled Observations/Assessment dated September 18, 2025, was identified by clinical nurse supervisor (CNS)-A as R1's most recent comprehensive assessment completed by CNS-A. R3 was admitted to the licensee on October 6, 2020. R3's Skilled Observations/Assessment dated September 18, 2025, was identified by CNS-A as R3's most recent comprehensive assessment completed by CNS-A. R4 was admitted to the licensee on December 13, 2024. R4's Skilled Observations/Assessment dated September 16, 2025, was identified by CNS-A as	{01620}		

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{01620}	Continued From page 10 R4's most recent comprehensive assessment completed by CNS-A. Each assessment used the same templated document and same assessment content. Each assessment lacked addressing the following content as required per Minnesota Administrative Rule 4659.0150: - activities of daily living; - instrumental activities of daily living; - allergies and sensitivities related to medication; - emotional and mental health conditions; - a review of medical, dental, and emergency room visits in the past 12 months; - a review of physical therapy, occupational therapy, speech therapy, or cognitive evaluations within the past 12 months; - list of treatments, including type, frequency, and level of assistance needed; - risk factors; - the need for follow-up referrals for additional medical or cognitive care by health professionals; and - who has decision-making authority for the resident. On November 18, 2025, at 2:30 p.m., CNS-A stated they had been using the licensee's supplied templated assessment form for each resident. CNS-A reviewed Minnesota Administrative Rule 4659.0150 and stated licensee's assessment template lacked multiple required areas to be assessed. CNS-A stated licensee would need to seek out a new template for assessments which would include all required content. The licensee's Initial and On-going Nursing Assessment of Residents policy dated September 15, 2022, lacked identification of	{01620}		

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{01620}	Continued From page 11 Minnesota Administrative Rule 4659.0150 and the required areas to be addressed with each resident assessment. No further information provided.	{01620}		

Electronically Delivered

December 2, 2025

Licensee
Cedar Cove Assisted Living
21596 Cedar Lake Road
Sauk Centre, MN 56378

RE: Project Number(s) SL28803016

Dear Licensee:

On November 19, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 12, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 12, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 12, 2025, found not corrected at the time of the November 19, 2025, follow-up survey and/or subject to penalty assessment are as follows:

1370-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (a) - $500.00
1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (b) - $500.00
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) - $500.00

The details of the violations noted at the time of this follow-up survey completed on November 19, 2025 (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, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

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

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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

Sincerely,

Jessie Chenze

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	R 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL28803016-2 On November 18, 2025, through November 19, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on June 5, 2025. At the time of the survey, there were four (4) residents receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}		

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

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{0 480}	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{01370} SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting;	{01370}		

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{01370}	Continued From page 3 (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of three unlicensed personnel ((ULP)-D). 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).	{01370}		

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{01370}	Continued From page 4 The findings include: ULP-D was hired on March 25, 2020, to provide direct care services to residents of the facility. ULP-D's employee record lacked documented evidence of the following required training/competency testing: - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and assistance with dressing and toileting; - training on the prevention of falls for providers working with elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional- understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On November 18, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated ULP-D had been a long-time employee and believed the licensee had completed training and competency testing prior to CNS-A's employment with the licensee. CNS-A stated the licensee had	{01370}		

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{01370}	Continued From page 5 completed the required training and testing for all recent new hires, but no documentation ULP-D had been trained and competency tested was located in ULP-D's record. CNS-A stated licensee had implemented a new training form for the recently hired staff and would use the new training form for ULP-D to ensure compliance with requirements. The licensee's Training and Competency Evaluation of Unlicensed Staff policy dated September 15, 2022, indicated all staff would meet all orientation and training requirements and be determined competent to perform all tasks by the registered nurse or other licensed health professional before they may provide any services to residents. No further information provided.	{01370}		
{01380} SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as	{01380}		

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{01380}	Continued From page 6 required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of three unlicensed personnel ((ULP)-D). 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: ULP-D was hired on March 25, 2020, to provide direct care services to residents of the facility. ULP-D's employee record lacked documented evidence of the following required training/competency testing: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and	{01380}		

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{01380}	Continued From page 7 - range of motion and positioning; - administering treatments as required. On November 18, 2025, at 1:30 p.m., clinical nurse supervisor (CNS)-A stated ULP-D had been a long-time employee and believed the licensee had completed training and competency testing prior to CNS-A's employment with the licensee. CNS-A stated the licensee had completed the required training and testing for all recent new hires, but no documentation ULP-D had been trained and competency tested was located in ULP-D's record. CNS-A stated licensee had implemented a new training form for the recently hired staff and would use the new training form for ULP-D to ensure compliance with requirements. The licensee's Training and Competency Evaluation of Unlicensed Staff policy dated September 15, 2022, indicated all staff would meet all orientation and training requirements and be determined competent to perform all tasks by the registered nurse or other licensed health professional before they may provide any services to residents. No further information provided.	{01380}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan	{01620}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{01620}	Continued From page 8 prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) 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}		

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{01620}	Continued From page 9 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 all areas of the uniform assessment tool as required per Minnesota Administrative Rule 4659.0150, were addressed for three of three residents (R1, R3, and R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on March 4, 2021. R1's Skilled Observations/Assessment dated September 18, 2025, was identified by clinical nurse supervisor (CNS)-A as R1's most recent comprehensive assessment completed by CNS-A. R3 was admitted to the licensee on October 6, 2020. R3's Skilled Observations/Assessment dated September 18, 2025, was identified by CNS-A as R3's most recent comprehensive assessment	{01620}		

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{01620}	Continued From page 10 completed by CNS-A. R4 was admitted to the licensee on December 13, 2024. R4's Skilled Observations/Assessment dated September 16, 2025, was identified by CNS-A as R4's most recent comprehensive assessment completed by CNS-A. Each assessment used the same templated document and same assessment content. Each assessment lacked addressing the following content as required per Minnesota Administrative Rule 4659.0150: - activities of daily living; - instrumental activities of daily living; - allergies and sensitivities related to medication; - emotional and mental health conditions; - a review of medical, dental, and emergency room visits in the past 12 months; - a review of physical therapy, occupational therapy, speech therapy, or cognitive evaluations within the past 12 months; - list of treatments, including type, frequency, and level of assistance needed; - risk factors; - the need for follow-up referrals for additional medical or cognitive care by health professionals; and - who has decision-making authority for the resident. On November 18, 2025, at 2:30 p.m., CNS-A stated they had been using the licensee's supplied templated assessment form for each resident. CNS-A reviewed Minnesota Administrative Rule 4659.0150 and stated licensee's assessment template lacked multiple	{01620}		

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{01620}	Continued From page 11 required areas to be assessed. CNS-A stated licensee would need to seek out a new template for assessments which would include all required content. The licensee's Initial and On-going Nursing Assessment of Residents policy dated September 15, 2022, lacked identification of Minnesota Administrative Rule 4659.0150 and the required areas to be addressed with each resident assessment. No further information provided.	{01620}		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 13, 2025

Licensee
Cedar Cove Assisted Living
21596 Cedar Lake Road
Sauk Centre, MN 56378

RE: Project Number(s) SL28803016

Dear Licensee:

On June 5, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on February 12, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the February 12, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on February 12, 2025, found not corrected at the time of the June 5, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0680-Disaster Planning And Emergency Preparedness-144g.42 Subd. 10 - $500.00
0900-Contract Required-144g.50 Subdivision 1
1370-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (a) - $500.00
1380-Training And Evaluation Of Unlicensed Personn-144g.61 Subd. 2 (b) - $500.00
1440-Supervision Of Staff Providing Delegated Nurs-144g.62 Subd. 4 - $500.00
1620-Initial Reviews, Assessments, And Monitoring-144g.70 Subd. 2 (c-E) - $500.00
1640-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (a-E)
1650-Service Plan, Implementation And Revisions To-144g.70 Subd. 4 (f) - $500.00
1700-Provision Of Medication Management Services-144g.71 Subd. 2 - $500.00
1820-Prescriptions-144g.71 Subd. 13
1880-Storage Of Medications-144g.71 Subd. 19

The details of the violations noted at the time of this follow-up survey completed on June 5, 2025 (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.

Also, at the time of this follow-up survey completed on June 5, 2025, we identified the following violation(s):

1060-Emergency Relocation-144g.52 Subd. 9
1690-Medication Management Services-144g.71 Subdivision 1

1710-Individualized Medication Monitoring And Reas-144g.71 Subd. 3
1730-Individualized Medication Management Plan-144g.71 Subd. 5
1930-Policies And Procedures-144g.72 Subd. 2
1940-Individualized Treatment Or Therapy Managemen-144g.72 Subd. 3
1950-Administration Of Treatments And Therapy-144g.72 Subd. 4

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these state correction orders. It is not necessary to develop a plan of correction.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Cedar Cove Assisted Living. Please contact Jessie Chenze at 218-332-5175 on or before Augest 18th, 2025 to schedule the conference call.
We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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

Sincerely,



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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	R 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 000}	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL28803016-1 On June 4, 2025, through June 5, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on February 12, 2025. At the time of the survey, there were four (4) residents receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued and/ or issued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}		

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

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must	{0 680}		

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{0 680}	Continued From page 3 make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, 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 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: On June 4, 2025, at 9:30 a.m., surveyor requested licensee's EPP from assisted living director in residency (ALDIR)-B. On June 4, 2025, at 10:00 a.m., ALDIR-B stated licensee had not developed an EPP at that time. ALDIR-B stated licensee was aware an EPP was required to be completed but licensee had not developed or implemented an EPP.	{0 680}		

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{0 680}	Continued From page 4 Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided.	{0 680}		
{0 900} SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer	{0 900}		

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{0 900}	Continued From page 5 contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain authentication on licensee's current assisted living contract for one of one resident (R5). 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: R5 was admitted to licensee on April 6, 2021. R5's Service Plan dated August 1, 2022, indicated R5 required medication administration, assistance with room cleaning and laundry, monitor behaviors, and vitals. During licensee's survey completed on February 12, 2025, licensee was issued citations related to licensee's assisted living contract lacking required content and required the licensee to create an	{0 900}		

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{0 900}	Continued From page 6 assisted living contract with all required content. On June 4, 2025, at 9:00 a.m., licensee's new blank assisted living contract with required content was provided to surveyor for review. On June 4, 2025, at 11:30 a.m., assisted living director in residency (ALDIR)-B stated licensee did not obtain authentication on licensee's new contract from R5 or from any resident living at the facility. ALDIR-B stated licensee's new contract would need to be provided to each resident or resident's designated representative for authentication. No further information provided.	{0 900}		
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 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	01060		

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01060	Continued From page 7 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 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 the required content for an emergency relocation to the resident, legal representative, or designated representative 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 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).	01060		

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01060	Continued From page 8 The findings include: R5 was admitted to licensee on April 6, 2021. R5's Service Plan dated August 1, 2022, indicated R5 required medication administration, assistance with room cleaning and laundry, monitor behaviors, and vitals. R5's Progress Note dated May 2, 2025, at 2:30 p.m., indicated R5 was sent to a local emergency room (ER) due to blood clots noted in R5's catheter bag. R5's Progress Note dated May 2, 2025, at 8:00 p.m., indicated the ER planned to keep R5 overnight due to the clots. R5's Progress Notes dated May 3, 2025, through May 5, 2025, indicated R5 was admitted to the hospital. R5's Progress Note dated May 6, 2025, at 3:30 p.m., indicated R5 returned from the hospital and was readmitted under the licensee's care and services. On June 5, 2025, at 8:55 a.m., assisted living director in residency (ALDIR)-B stated licensee was not aware of the emergency relocation notice requirements. ALDIR-B stated licensee had never provided an emergency relocation notice to R5 or to any other resident that had an emergency relocation. ALDIR-B stated a notice would need to be created and implemented. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one	01060		

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01060	Continued From page 9 (21) days	01060		
{01370} SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family;	{01370}		

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{01370}	Continued From page 10 (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for two of two unlicensed personnel ((ULP)-D and ULP-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D was hired on March 25, 2020, to provide direct care services to residents of the facility. ULP-F was hired on April 17, 2025, to provide direct care services to residents of the facility. ULP-D and ULP-F's employee records lacked documented evidence of the following required training/competency testing: - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including hair care and	{01370}		

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CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{01370}	Continued From page 11 bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and assistance with dressing and toileting; - training on the prevention of falls for providers working with elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional- understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On June 4, 2025, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated training and competencies were not completed and documented in the ULP's records. CNS-A stated each ULP had been trained but competencies and documentation of the training were not completed. Assisted living director in residency (ALDIR)-B stated the documentation of the training and competencies should have been completed and documented in each employee's record when completed. The licensee's Training and Competency policy dated September 15, 2022, noted the ULP would meet all orientation and training requirements and be determined competent to perform all tasks by the registered nurse or other licensed health professional before they may provide any services to residents. No further information provided.	{01370}		

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{01380}	Continued From page 12	{01380}		
{01380} SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for two of two unlicensed personnel ((ULP)-D and ULP-F). 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).	{01380}		

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{01380}	Continued From page 13 The findings include: ULP-D was hired on March 25, 2020, to provide direct care services to residents of the facility. ULP-F was hired on April 17, 2025, to provide direct care services to residents of the facility. ULP-D and ULP-F's employee record lacked documented evidence of the following required training/competency testing: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motion and positioning; - administering treatments as required. On June 4, 2025, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated training and competencies were not completed and documented in the ULP's record. CNS-A stated each ULP had been trained but competencies and documentation of the training were not completed. Assisted living director in residency (ALDIR)-B stated the documentation of the training and competencies should have been completed and documented in each employee's record when completed. The licensee's Training and Competency policy dated September 15, 2022, noted the ULP would meet all orientation and training requirements and	{01380}		

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{01380}	Continued From page 14 be determined competent to perform all tasks by the registered nurse or other licensed health professional before they may provide any services to residents. No further information provided.	{01380}		
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided	{01440}		

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{01440}	Continued From page 15 within 30 calendar days after the date on which the individual began working for the licensee for one of two unlicensed personnel, (ULP)-F. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-F was hired on April 17, 2025, to provide direct care services to all residents of the facility. ULP-F's employee record lacked documented evidence of a supervision of performing delegated tasks within 30 calendar days. On June 4, 2025, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated ULP-F had been recently hired and CNS-A should have completed a 30-calendar day direct supervision of nursing delegated task but CNS-A had not completed one yet. CNS-A stated they had delegated nursing tasks to ULP-F and had trained them but had not completed direct supervision of ULP-F and had not documented a supervision visit in ULP-F's record. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated September 15, 2022, noted director supervision of unlicensed staff performing delegated nursing tasks must be performed within 30 days after the person began working and had been trained and determined	{01440}		

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{01440}	Continued From page 16 competent to perform all tasks assigned. No further information was provided.	{01440}		
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living	{01620}		

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{01620}	Continued From page 17 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. (f) 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 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 observation, interview, and record review, the licensee failed to ensure all areas of the uniform assessment tool as required per Minnesota Administrative Rule 4659.0150 were addressed and failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 days, as required, for two of two residents (R1 and R4). 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:	{01620}		

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{01620}	Continued From page 18 R1 and R4 were admitted to the licensee on March 4, 2021, and December 13, 2024, respectively. Throughout the survey, R1 was observed in the living room watching TV and interacting with staff with meals and encouragement to participate in activities. R1's Service Plan dated August 1, 2022, noted R1 received services including medication administration, and assistance with room cleaning. R4's Service Plan was not provided during the course of the survey. R1 and R4's RN Baseline Assessment Form both dated January 8, 2025, were identified by assisted living director in residency (ALDIR)-B as R1 and R4's most recent assessments. A total of 147 days had passed since R1's most recent assessment and the initiation of this survey. R1 and R4's assessment lacked the following required content: - a review of medications according to Minnesota (MN) statutes, section 144G.71, Subd. 2, including the reason taken, any side effects, contraindications, allergic or adverse reactions, and actions to address those issues, dosage, frequency of use, route administered, and any difficulties the resident faces in taking the medication; - a review of medical, dental, and emergency room visits in the past 12 months; - a review of physical therapy, occupational therapy, speech therapy, or cognitive evaluations within the past 12 months; - list of treatments, including type, frequency, and	{01620}		

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{01620}	Continued From page 19 level of assistance needed; - risk factors; and - the need for follow-up referrals for additional medical or cognitive care by health professionals. On June 4, 2025, at 11:30 a.m., assisted living director in residency (ALDIR)-B stated the above content was not included on either assessment documents utilized by the licensee. ALDIR-B stated licensee's assessment templates did not included all required content per Minnesota Rules Chapter 4659.0140, Subp. 2. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. The licensee's Initial and On-going Nursing Assessment of Residents policy dated September 15, 2022, noted the assessment must not exceed 90 days from the date of the last assessment. The policy lacked identification of required content of an assessment.	{01620}		

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{01620}	Continued From page 20 No further information provided.	{01620}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan with included signature or other authentication by the resident to document agreement on the services to be provided was maintained for one of three residents (R4). This practice resulted in a level two violation (a	{01640}		

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{01640}	Continued From page 21 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: R4 was admitted to the licensee on December 13, 2024. R4's RN Baseline Assessment Form dated January 8, 2025, indicated R4 required assistance with bathing, transfers, mobility, finance management, and arranging appointments. R4's record lacked a completed and authenticated service plan. On June 4, 2025, at 11:30, assisted living director in residency (ALDIR)-B stated licensee was unable to locate a service plan in R4's record and was not sure if one was completed and authenticated when R4 was admitted. The licensee's Contents of Service Plans policy dated September 15, 2022, indicated all residents would have a completed and authenticated service plan to document agreement of services to be provided would be maintained in each resident's record. No further information provided.	{01640}		

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{01650}	Continued From page 22	{01650}		
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee's service plan included the required content for two of two residents (R1 and R5). This practice resulted in a level two violation (a	{01650}		

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{01650}	Continued From page 23 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 and R5 were admitted to the licensee on March 4, 2021, and April 6, 2021, respectively. R1 and R5's Service Plans were both dated August 1, 2022. R1's Service plan lacked identification of the schedule and methods of monitoring assessments of the resident and the schedule and methods of monitoring staff providing services. R5's Service plan lacked identification of the schedule and methods of monitoring assessments of the resident, the schedule and methods of monitoring staff providing services, and the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. On June 4, 2025, at 12:10 p.m., assisted living director in residency (ALDIR)-B stated licensee's service plan template did not include the missing content identified above. ALDIR-B stated a new template would need to be created to ensure all required content was included and then	{01650}		

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{01650}	Continued From page 24 authenticated by each resident. The licensee's Contents of Service Plans policy dated September 15, 2022, indicated all required content for a resident service plan but was not implemented into the licensee's templated service plan used for all residents. No further information provided.	{01650}		
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are	01690		

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01690	Continued From page 25 being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written individualized medication management program (IMMP) policies and procedures that were developed under the supervision and direction of a registered nurse (RN). 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: On June 4, 2025, at 11:45 a.m., the surveyor requested licensee's policy and procedure related to licensee's IMMP from assisted living director in residency (ALDIR)-B. ALDIR-B stated licensee maintained policy and procedures in a 3-ringed binder but the could not locate an IMMP policy or procedure in the 3-ringed binder but would review the licensee's digital versions. On June 5, 2025, at 9:30 a.m., ALDIR-B stated licensee's clinical nurse supervisor (CNS)-A would be coming to the facility and would bring	01690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	R 06/05/2025

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01690	Continued From page 26 licensee's IMMP policy and procedures. On June 5, 2025, at 9:45 a.m., CNS-A arrived at the facility. CNS-A stated all policies and procedures are to be maintained in the identified 3-ringed binder. CNS-A stated licensee must have misplaced the IMMP policy and procedure and was not sure where it would be located. On June 5, 2025, at 10:30 a.m., the survey concluded, and licensee was not able to provide an IMMP policy and procedure which was implemented. The licensee's Medication Management Services policy dated September 15, 2022, indicated the RN was responsible for the development, maintenance, and implementation of a IMMP policy and procedure. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
{01700} SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the	{01700}		

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{01700}	Continued From page 27 resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of three residents (R5) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents) The findings include: R5 was admitted to the licensee on April 6, 2021.	{01700}		

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	28803	A. BUILDING: _____ B. WING _____	R 06/05/2025

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{01700}	Continued From page 28 R5's Service Plans dated August 1, 2022, indicated R5 required medication administration services. R5's Skilled Observation/Assessment dated April 25, 2025, under the Medications section included an "X" marked next to, "Updated Medication Profile," and handwriting from clinical nurse supervisor (CNS)-A which read, "Many changes were made." R5's medication reassessment lacked indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to be taken to address them if they arose. On June 5, 2025, at 9:18 a.m., assisted living director in residency (ALDIR)-B stated R5's medication reassessment when medication changes occurred was not completed face to face and did not address all required content for medications R5 was ordered by their provider. ALDIR-B stated CNS-A should have completed a full medication reassessment with all required content when the changes occurred. The licensee lacked an individualized medications management program policy which indicated when medication assessment and reassessment would occur and the required content of the medication assessment. No further information provided.	{01700}		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered	01710		

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01710	Continued From page 29 nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. 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 annual re-assessments for an individualized medication management plan (IMMP) for two of two residents (R1 and R5) who received medication management services for longer than one year. 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: R1 R1 was admitted to the licensee on March 4, 2021. R1's [licensee] Client Individualized Mediations Management Plan dated December 30, 2021, was identified by assisted living director in residency (ALDIR)-B as R1's most recent RN IMMP assessment.	01710		

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01710	Continued From page 30 R1's Service Plan dated August 1, 2022, indicated R1 required medication administration services. R5 R5 was admitted on April 6, 2021. R5's Service Plan dated August 1, 2022, indicated R5 required medication administration services. R5's record lacked a [licensee] Client Individualized Mediations Management Plan document. On June 5, 2025, at 9:18 a.m., ALDIR-B stated R1 and R5's records lacked annual reassessment for their IMMP. ALDIR-B stated licensee had not required a registered nurse to reassess R1 or R5's IMMP annually as required. As citation 1690 indicated, the licensee lacked an IMMP policy and procedure as required. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The	01730		

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01730	Continued From page 31 facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01730		

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01730	Continued From page 32 licensee failed to develop an individualized medication management plan (IMMP) with the required content for two of two residents (R1 and 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 of the residents). The findings include: R1 R1 was admitted to the licensee on March 4, 2021. R1's [licensee] Client Individualized Mediations Management Plan dated December 30, 2021, was identified by assisted living director in residency (ALDIR)-B as licensee's IMMP for R1. A section that read, "Any special procedures related to storage of medications to prevent diversion:" was blank and did not include instructions to prevent diversion. R1's Service Plan dated August 1, 2022, indicated R1 required medication administration services. R5 R5 was admitted on April 6, 2021. R5's Service Plan dated August 1, 2022, indicated R5 required medication administration services.	01730		

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	28803	A. BUILDING: _____ B. WING _____	R 06/05/2025

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01730	Continued From page 33 R5's record lacked a [licensee] Client Individualized Mediations Management Plan document as identified by ALDIR-B for R1 as licensee's IMMP. As a result, R5's lacked any IMMP with all required content. On June 5, 2025, at 9:18 a.m., ALDIR-B stated R1 and R5's records lacked a fully developed IMMP with all required content. ALDIR-B stated clinical nurse supervisor (CNS)-A would need to reassess R1's IMMP to include the missing information and CNS-A would need to develop a complete IMMP for R5 due to one not being created or located in R5's record. As citation 1690 indicated, the licensee lacked an IMMP policy and procedure as required. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
{01820} SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of two residents (R5).	{01820}		

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{01820}	Continued From page 34 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 was admitted on April 6, 2021. R5's Service Plan dated August 1, 2022, indicated R5 required medication administration services. R5's After Visit Summary (AVS) dated May 15, 2025, was not signed or authenticated by a licensed ordering provider. On the AVS under Instructions, three medication changes were noted for acetaminophen (generic name for Tylenol, a common over the counter pain reliever), atorvastatin (generic name for Lipitor, a lipid lowering medication), and albuterol sulfate (an inhaled medication used to aid in breathing). Next to the three medication changes were the initials of assisted living director in residency (ALDIR)-B with the date of May 15, 2025, and a note that read, "RN Notified." R5's Medication/Treatment Record dated June 2025, included the medication changes noted on the aforementioned AVS with initials next to the medications on different scheduled times with multiple staff initials in place to document the administration of the current medications. The discontinued albuterol sulfate had been removed from R5's June 2025, Medication/Treatment	{01820}		

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	28803	A. BUILDING: _____ B. WING _____	R 06/05/2025

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{01820}	Continued From page 35 Record. On June 5, 2025, at 9:18 a.m., ALDIR-B stated licensee used R5's unsigned AVS as provider orders to make changes to R5's medications. ALDIR-B stated licensee believed since the AVS was coming from the provider's office, the AVS could be used as a signed order. ALDIR-B stated licensee would have clinical nurse supervisor (CNS)-A review each resident record and ensure signed orders were obtained for all medications being provided by the licensee. The licensee's Medication Management Services policy dated September 15, 2022, indicated all medications would be administered per a valid prescription. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	{01820}		
{01880} SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of two residents (R5). This practice resulted in a level two violation (a	{01880}		

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	28803	A. BUILDING: _____ B. WING _____	R 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01880}	Continued From page 36 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: On June 5, 2025, at 8:10 a.m., during medication administration observation performed by unlicensed personnel (ULP)-C, three over the counter (OTC) medications were noted on R5's dresser. A tube of generic pain reliving cream, a tube of Preparation H (medicated cream to treat hemorrhoids), and a tube of Bengay (a topical pain relieving cream) were stored in R5 room unsecured and accessible by R5. R5 was admitted on April 6, 2021. R5's Service Plan dated August 1, 2022, indicated R5 required medication administration services. R5's After Visit Summary (AVS) dated May 15, 2025, was identified by assisted living director in residency (ALDIR)-B as R5's most recent reviewed medication list lacked any indication R5 had a current prescribed order for any of the three medications stored in R5 room. R5's Medication/Treatment Record dated June 2025, was identified by ALDIR-B as all R5's medications licensee would administer lacked the three medications identified in R5's room. On June 5, 2025, at 9:13 a.m., ULP-C stated	{01880}		

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	28803	A. BUILDING: _____ B. WING _____	R 06/05/2025

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{01880}	Continued From page 37 licensee was not aware of the medications in R5's room. ULP-C stated if there were medications in R5's room, R5 obtained them on their own as all medications should be secured in licensee's medication cart. On June 5, 2025, at 9:18 a.m., ALDIR-B stated R5 should not have any medications in their room as R5 has not been assessed by a registered nurse (RN) to self-administer any medications. ALDIR-B stated if R5 was using the OTC medications, they were not being documented as administered. ALDIR-B stated R5's provider had not been updated with the OTC medications in R5 room and the RN would need to update the provider and pharmacy to ensure the medications were safe to be administered with R5's other medications. The licensee's Storage of Medications policy dated September 15, 2022, indicated all medications managed by licensee would be stored according to a resident's assessment. No further information provided.	{01880}		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must	01930		

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01930	Continued From page 38 address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written individualized treatment management program (ITMP) policies and procedures that were developed under the supervision and direction of a registered nurse (RN). 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: On June 4, 2025, at 11:45 a.m., the surveyor requested licensee's policy and procedure related to licensee's ITMP from assisted living director in residency (ALDIR)-B. ALDIR-B stated licensee maintained policy and procedures in a 3-ringed binder but the could not locate an ITMP policy or procedure in the 3-ringed binder but would review the licensee's digital versions. On June 5, 2025, at 9:30 a.m., ALDIR-B stated	01930		

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01930	Continued From page 39 licensee's clinical nurse supervisor (CNS)-A would be coming to the facility and would bring licensee's ITMP policy and procedures. On June 5, 2025, at 9:45 a.m., CNS-A arrived at the facility. CNS-A stated all policies and procedures are to be maintained in the identified 3-ringed binder. CNS-A stated licensee must have misplaced the ITMP policy and procedure and was not sure where it would be located. On June 5, 2025, at 10:30 a.m., the survey concluded, and licensee was not able to provide an ITMP policy and procedure which was implemented. The licensee lacked an individualized treatment management program policy as required. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided;	01940		

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	28803	A. BUILDING: _____ B. WING _____	R 06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

(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
01940	Continued From page 40 (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan with all required content for one of one resident (R5) who had a treatment. 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). Findings include: On June 5, 2025, at 8:10 a.m., observed an oxygen concentrator in the common hallway with	01940		

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01940	Continued From page 41 tubing leading from the concentrator to R5's door, under the door, and provided oxygen to R5. Additionally, observed unlicensed personnel (ULP)-C provide catheter cares to R5 of removal of a catheter securement device, apply a new device, and catheter cleaning and maintenance. R5 was admitted on April 6, 2021. R5's Service Plan dated August 1, 2022, lacked identification R5 received any treatment services provided by the licensee. R5's Medication/Treatment Record dated June 2025, included documentation daily for R5's following treatments: - Catheter care done daily; - Oxygen application and adjustment based on activity daily; and - Compression Stocking application and removal daily. R5's treatment record lacked the following: - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. On June 5, 2025, at 9:18 a.m., ALDIR-B stated	01940		

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01940	Continued From page 42 licensee did not update R5's service plan when R5 required treatment services and did not have the clinical nurse supervisor (CNS)-A develop a completed treatment plan with all required content. ALDIR-B stated CNS-A would need to update R5's assessment, service plan, and create a complete individualized treatment management plan for all treatments R5 received. As indicated in citation 1930, the licensee lacked an individualized treatment management plan policy. The licensee's Contents of Service Plans policy dated September 15, 2022, indicated all services provided by licensee would be included on an authenticated services plan prior to the provision of the services. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the	01950		

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01950	Continued From page 43 proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include specified, in writing, specific instructions for one of one resident (R5) who had a treatment. 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). Findings include: On June 5, 2025, at 8:10 a.m., observed an oxygen concentrator in the common hallway with tubing leading from the concentrator to R5's door, under the door, and provided oxygen to R5. Additionally, observed unlicensed personnel (ULP)-C provide catheter cares to R5 of removal of a catheter securement device, apply a new device, and catheter cleaning and maintenance. R5 was admitted on April 6, 2021. R5's Service Plan dated August 1, 2022, lacked identification R5 received any treatment services provided by the licensee.	01950		

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01950	Continued From page 44 R5's Medication/Treatment Record dated June 2025, included documentation daily for R5's following treatments: - Catheter care done daily; - Oxygen application and adjustment based on activity; and - Compression Stocking application and removal daily. R5's treatment record lacked any resident specific instruction for the administration of any treatment and when ULPs would not administer the treatment or when to contact a licensed health professional when issues would arise. On June 5, 2025, at 9:18 a.m., ALDIR-B stated licensee did not have the clinical nurse supervisor (CNS)-A develop a completed treatment plan with all required content. ALDIR-B stated CNS-A would need to re-assess R5 and create a complete individualized treatment management plan with specific instructions for all treatments R5 received. As indicated in citation 1930, the licensee lacked an individualized treatment management plan policy. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

Electronically Delivered

March 11, 2025

Licensee
Cedar Cove Assisted Living
21596 Cedar Lake Road
Sauk Centre, MN 56378

RE: Project Number(s) SL28803016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 12, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Cedar Cove Assisted Living. Please contact Jessie Chenze at 218-332-5175 on or before Friday, March 14, 2025, to schedule the conference call.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

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0 000	Initial Comments 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: SL28803016 On February 10, 2025, through February 12, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 4 residents; 4 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with correction orders (tag identification: 0470, 0480, 0580, 0650, 0660, 0680, 0780, 0790, 0800, 0810, 0820, 0900, 1820) for a survey completed on February 12, 2025. This had the potential to affect all residents, staff, and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 340		

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0 340	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 10, 2025, at 9:15 a.m., assisted living director in residency (ALDIR)-B stated she was familiar with the current minimum assisted living requirements. The licensee provided an undated State Survey Corrective Action Plan, which consisted of 13 pages including the following information: - 0470: develop staffing plan in accordance with guidelines and evaluate at least twice per year, with completion date of August 17, 2022; - 0480: ensure all raw meat has a stamp on the package when purchased from supplier, with completion date of July 27, 2022, use bleach and water mixture with completion date of July 25, 2022, provide chlorine test strips for bleach sanitizer with correction date of July 30, 2022, and throw all leftovers away with correction date of July 25, 2022; - 0580: implement staff meetings at least quarterly with notes taken with each meeting with correction date August 17, 2022; - 0650: have all employee records complete with all required paperwork with correction date of August 17, 2022; - 0660: revise tuberculosis infection control program and ensure all staff have a two-step skin test upon hire with a correction date of August 17, 2022; - 0680: revise disaster plan with current information and post prominently on bulletin	0 340		

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0 340	Continued From page 3 board in plain view, update written policy regarding missing residents and provide disaster training to all new hires as well as periodically to existing staff and annually to residents with completion date of August 17, 2022; - 0780: install smoke alarms in each bedroom, outside each bedroom in immediate vicinity, each story of facility as well as ensure all are interconnected with correction date of August 21, 2022; - 0790: install and maintain portable fire extinguishers within 75 feet of each other and maintain records of monthly service of fire extinguishers with correction date of August 20, 2022; - 0800: to keep physical environment including walls, floor, ceiling, all furnishings, grounds, systems and equipment in a continuous state of good repair and operation with correction date of September 3, 2022; - 0810: maintain fire safety and evacuation plans including the location and number of resident sleeping rooms, employee actions to be taken in the event of a fire or similar emergency, fire protection procedures necessary for residents, procedures for resident movement, evacuation or relocation during a fire or similar emergency including identification of unique or unusual resident needs for movement or evacuation, employee training of fire safety and evacuation plans at least twice per year, fire safety and evacuation plans readily available at all times, training of residents to be done yearly, employee evacuation drills at least every other month, and employee training documentation of fire safety with correction date of August 31, 2022; - 0820: install new egress window in room #1 with correction date of August 9, 2022; - 0900: revise service contract within assisted living guidelines and obtain signatures from	0 340		

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0 340	Continued From page 4 residents and/or guardians with correction date of August 10, 2022; and - 1820: Obtain signed medication orders from all providers for all medications with correction date of September 1, 2022. On February 12, 2025, at 10:00 a.m., ALDIR-B stated the former licensed assisted living director/clinical nurse supervisor was responsible for the plan of corrections. On February 12, 2025, the survey concluded, and correction orders 0470, 0480, 0580, 0650, 0660, 0680, 0780, 0790, 0800, 0810, 0820, 0900, and 1820 were reissued. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. This had the	0 420		

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0 420	Continued From page 5 potential to affect all 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 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 an assisted living license, effective February 1, 2025. During the entrance conference on February 10, 2025, at 9:15 a.m., assisted living director in residency (ALDIR)-B stated she was familiar with the assisted living regulations, and the licensee provided medication management services. The licensee's renewal "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all	0 420		

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0 420	Continued From page 6 attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner/authorized agent on November 11, 2023. As a result of this survey, the following orders were issued under 0340, 0470, 0480, 0485, 0490, 0500, 0530, 0580, 0630, 0650, 0660, 0680, 0730, 0775, 0780, 0790, 0800, 0810, 0900, 0910, 0920, 0930, 0940, 0950, 1370, 1380, 1440, 1460, 1470, 1500, 1530, 1560, 1620, 1640, 1650, 1700, 1790, 1820, 1880, 1890, 1900, 1910, and 2320, which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

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0 470	Continued From page 7 by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year. This had the potential to affect all 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 470		

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0 470	Continued From page 8 a large portion or all of the residents). The findings include: The licensee held an assisted living license and was licensed for a capacity of 5 residents, with a current census of 4 residents. During the entrance conference on February 10, 2025, at 9:15 a.m., assisted living director in residency (ALDIR)-B stated she was familiar with the current minimum assisted living requirements. The licensee's Staffing Plan dated December 9, 2023, indicated the former clinical nursing supervisor (CNS) / licensed assisted living director developed and implemented the written staffing plan. However, the plan lacked documentation it had been reviewed at least twice per year. On February 11, 2025, at 1:30 p.m., CNS-A and assisted living director in residency (ALDIR)-B stated the staffing plan had been developed by the previous licensed assisted living director/CNS, and had not been reviewed by the current CNS. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	0 480		

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0 480	Continued From page 9 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480		

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0 480	Continued From page 10 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 10, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 485	Continued From page 11	0 485		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post a complete menu a week in advance that was made available to all residents. In addition, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all 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).	0 485		

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0 485	Continued From page 12 The findings include: During the initial tour on February 10, 2025, at 10:20 a.m., with assisted living director in residency (ALDIR)-B, the surveyor did not observe a menu posted. On February 11, 2025, at 8:18 a.m., unlicensed personnel (ULP)-D was working on the menu dated February 9, 2025, through February 15, 2025, and February 16, 2025, through February 22, 2025, at the dining room table. ULP-D stated she prepares the menu, and said breakfast and alternate meals are not included on the menu. ULP-D stated at breakfast the residents all eat their own thing and for alternates, residents can have a sandwich if they don't want the offered meal. ULP-D stated this is not included on the menu. The licensee's undated Service Agreement, identified as the contract, noted on Attachment A, "The following is a description of the services We make Available to Our Residents, and a fee schedule for those services. (3 meals and 3 snacks included in every package)." On February 12, 2025, at 10:35 a.m., assisted living director in residency (ALDIR)-B and clinical nurse supervisor (CNS)-A stated the same template was utilized for all residents, and all meals and snacks were included in the plans. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		

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0 490	Continued From page 13	0 490		
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all 4 residents of the facility. This practice resulted in a level two violation (a	0 490		

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0 490	Continued From page 14 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 10, 2025, at 9:15 a.m., assisted living director in residency (ALDIR)-B stated activities were available, but there was not much participation from the residents. During the course of the survey, the licensee observed R1 spend a majority of the time seated in the living room watching television. At one point, R1 did come to the dining room table and color when offered. Of the remaining three residents, one went out to work two of the three days, one only came down for meals, and the other resident remained in her room. On February 11, 2025, at 12:00 p.m., ALDIR-B stated the licensee did not offer daily activity programs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following	0 500		

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0 500	Continued From page 15 and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel	0 500		

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0 500	Continued From page 16 performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement current policies and procedures, as required. 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: During the entrance conference on February 10, 2025, at 9:15 a.m., assisted living director in residency (ALDIR)-B stated she was familiar with the assisted living regulations. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the Assisted Living Bill of Rights;	0 500		

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0 500	Continued From page 17 - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; and - supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued under 0650, 0660, 1370, 1380, 1440, 1460, 1470, 1480, 1500, 1530, 1620, 1700, 1790, 1820, 1880, 1900, 1910, 2240. During the course of the survey, ALDIR-B and clinical nurse supervisor (CNS)-A stated the policies had not been implemented as evidenced by the interviews in the above noted orders. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 500		
0 530 SS=C	144G.41 Subd. 5 Resident councils The facility must provide a resident council with space and privacy for meetings, where doing so is reasonably achievable. Staff, visitors, and other guests may attend a resident council meeting only at the council's invitation. The facility must designate a staff person who is approved by the resident council to be responsible for providing assistance and responding to written requests that result from meetings. The facility must consider the views of the resident council and must respond promptly to the grievances and recommendations of the council, but a facility is not required to implement as recommended	0 530		

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0 530	Continued From page 18 every request of the council. The facility shall, with the approval of the resident council, take reasonably achievable steps to make residents aware of upcoming meetings in a timely manner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide space and requirements for resident council. The licensee failed to make it known to residents, they were allowed to form a council if desired. This had the potential to affect all residents receiving assisted living services. 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: During the entrance conference on February 10, 2025, at 9:15 a.m., when asked if she had provided space and privacy for resident council meetings, assisted living director in residency (ALDIR)-B stated they have never had or offered resident council or the space or privacy because "we are so small and can just talk to them about their needs." In addition, ALDIR-B stated a staff person had not been designated. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 530		

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0 580	Continued From page 19	0 580		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size and relevant to the type of services provided by the assisted living facility. This had the potential to affect the licensee's current resident. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 580		

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0 580	Continued From page 20 During the entrance conference on February 10, 2025, at 9:15 a.m., assisted living director in residency (ALDIR)-B stated she was not aware if the prior licensed assisted living director/clinical nurse supervisor (CNS) held any quality management meetings and no documentation was available. On February 10, 2025, at 11:10 a.m., CNS-A stated she held monthly staff meetings and had discussed documentation and infection control. Another topic for next month was emergency preparedness, and she was developing a plan to see what needed to be looked at. CNS-A stated she had one staff meeting in November 2024, and one in January 2025 with the above topics. The licensee's undated Quality Management Plan policy noted the licensee would establish a quality management program to develop and maintain continuous performance improvement efforts, to meet at least quarterly, including complaints, vulnerable adult reports, incident reports, medication errors, resident and personnel record audits, current data on dashboard measures, survey results, and other relevant information. It also noted documents would be retained for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each	0 630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

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0 630	Continued From page 21 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 an individual abuse prevention plan (IAPP) was developed to include the required content for one of one resident (R1). 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's diagnoses included seizures, depression, and developmental disability. Throughout the survey, R1 was observed in the living room watching TV. R1's Service Plan dated August 10, 2022, noted R1 received services including medication administration, and assistance with room	0 630		

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0 630	Continued From page 22 cleaning. R1's undated IAPP noted R1 exhibited physical aggression toward others, and noted R1 at times was redirectable. However, it lacked the resident's susceptibility to abuse by another individual and statements of specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults. On February 11, 2025, at 12:25 p.m., assisted living director in residency (ALDIR)-B and clinical nurse supervisor (CNS)-A stated the IAPP was completed by CNS-A on January 8, 2025, the same date as the assessment was completed. They stated the same template was utilized for all residents, and it lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including	0 650		

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0 650	Continued From page 23 qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for one of three employees (unlicensed personnel/ULP-D). 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: ULP-D was hired on March 25, 2020, to provide direct care services to residents of the facility. On February 11, 2025, from 7:35 a.m. through 7:45 a.m., ULP-D was observed to administer medications to residents. ULP-D's employee record lacked documented	0 650		

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0 650	Continued From page 24 evidence of the following: - annual performance review. On February 12, 2025, at 11:55 a.m., ALDIR-B and CNS-A stated an annual performance evaluation had not been completed for ULP-D as required. The licensee's Personnel Records policy dated September 15, 2022, noted the personnel record would include evidence of current professional licensure and performance evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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	0 660		

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0 660	Continued From page 25 by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for three of three employees (clinical nurse supervisor/CNS-A, unlicensed personnel/ULP-D, ULP-E) and documentation of a completed health history and symptom screening for two of three employees (CNS-A, unlicensed personnel/ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment dated July 14, 2024, indicated the licensee was a low risk level. CNS-A CNS-A was hired on October 23, 2024, to provide direct care services to residents of the facility. CNS-A's employee record lacked documented evidence of the following: - two-step TST or other evidence of TB screening; and - documentation of a completed health history	0 660		

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0 660	Continued From page 26 and symptom screening. Upon request, CNS-A provided evidence of the TST and screening dated November 18, 2024, and December 6, 2024. On February 12, 2025, at 11:25 a.m., assisted living director in residency (ALDIR)-B and CNS-A stated a copy of the information was not available in CNS-A's employee record as required. ULP-D ULP-D was hired on March 25, 2020, to provide direct care services to residents of the facility. On February 11, 2025, from 7:35 a.m. through 7:45 a.m., ULP-D was observed to administer medications to residents. ULP-D's employee record contained a TB screening dated April 20, 2021. It also included an immunization summary dated January 9, 2023, what indicated a TST was administered on January 9, 2023. However, it lacked documented evidence of the following: - two-step TST or other evidence of TB screening, including evidence the test was read. On February 12, 2025, at 11:55 a.m., ALDIR-B and CNS-A stated ULP-D's employee record lacked the required content, and added they did not have evidence of the required TST or reading. ULP-E ULP-E was hired on July 1, 2024, to provide direct care services to residents of the facility. ULP-E's employee record lacked documented evidence of the following: - two-step TST or other evidence of TB	0 660		

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0 660	Continued From page 27 screening; and - documentation of a completed health history and symptom screening. On February 12, 2025, at 11:40 a.m., ALDIR-B and CNS-A stated they were not sure if ULP-E had completed the TST or history and symptom screening, and added it may be in the pile downstairs, but they were not sure. The licensee's TB Prevention and Control policy dated September 15, 2022, noted the registered nurse (RN) and director were responsible to screen all staff for TB and maintain all reports of TB screening in the personnel files. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. 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 (a) The facility must meet the following	0 680		

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0 680	Continued From page 28 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents receiving services under the assisted living license, 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	0 680		

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0 680	Continued From page 29 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the initial tour on February 10, 2025, at 10:20 a.m., with assisted living director in residency (ALDIR)-B, the surveyor observed the main entry to the facility on the main floor included a common dining area with the medication cart, a common sitting area, kitchen, staff bathroom, resident bathroom, and one bedroom. The upper level consisted of a common sitting area at the top of the stairs, and four bedrooms. The end of the hall had a door which was locked, that went out to the deck. The basement had a utility room and a large open area with two desks and a table full with papers on top. At this time, the location of the emergency preparedness plan was requested, and ALDIR-B stated she was not aware of the location or what that was. Unlicensed personnel (ULP)-C pointed to a yellow laminated sheet hanging on the wall. The licensee's untitled EPP dated revised October 14, 2023, lacked the following required content: - annual review/updates; - hazard vulnerability assessment; - quarterly review of the missing resident plan; - identification of at risk population needs like maintaining independence, communication, transportation, supervision, and medical care; - identification of which staff would assume specific roles in another's absence through succession planning and delegation of authority; - a process for cooperation and collaboration with local, tribal, regional, State and Federal EP to	0 680		

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0 680	Continued From page 30 maintain integrated response; - policy and procedure to address food, water, medical supplies, and pharmaceutical supplies whether evacuated or sheltered in place for staff and residents; - alternate sources of energy to maintain temperatures to protect resident health and safety, safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing, alarm systems, and sewage and waste disposal; - policy and procedure to include a system to track the location of on-duty staff and sheltered residents, and if on-duty staff and sheltered residents are relocated, the facility must document the specific name/location of the receiving facility or other location; - policy and procedure to address safe evacuation from the facility, including consideration of care and treatment needs of evacuees, staff responsibilities, identification of evacuation locations, primary / alternative communication means with external sources of assistance; - policy and procedure to shelter in place for residents, staff, and volunteers who remain in the facility; - policy and procedure to address the use of volunteers, including the process/role for integration; - policy and procedure to address the development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; - policy and procedure to address the role of the facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; - a written communication plan including: - annual review; - the names and contact information of	0 680		

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0 680	Continued From page 31 entities providing services under agreement, residents' physicians, other facilities, and volunteers; - contact information for Federal, State, tribal, local EP staff, State Licensing and Certification Agency, Office of Ombudsman for Long-Term Care; - primary and alternate means of communicating with facility staff and Federal, State, tribal, regional and local emergency management agencies; - method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; - means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(4); - means to providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee; - method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; - EP training and testing program that must be reviewed and updated annually; - training program to include initial training of new staff and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role and at least annually; - exercises to test the EP at least twice per year, including unannounced staff drills using the EP to include: - participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise or if	0 680		

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0 680	Continued From page 32 the facility experiences an actual emergency requiring activation of the plan, the facility is exempt from engaging in its next required full-scale exercise; - conduct an additional annual exercise that may include a second full-scale exercise that is community based or an individual, facility based functional exercise or mock disaster drill or table-top exercise; and - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events and revise the plan as needed. On February 12, 2025, at 12:05 p.m., ALDIR-B and clinical nurse manager (CNS)-A stated the EPP had not been reviewed since October 14, 2023. ALDIR-B stated the former licensed assisted living director/CNS was responsible for this. In addition, they stated they did not have the above required documentation. Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights;	0 730		

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CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

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0 730	Continued From page 34 (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2's record included a Transfer/Discharge Summary dated September 26, 2024, which noted R2 received medication management, cues/reminders, and bathing, noted R2 moved to another assisted living facility, goals were met, R2 was stable at discharge, and a discharge assessment was completed. However, it lacked: - diagnoses; - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results;	0 730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

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0 730	Continued From page 35 and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. R2 admitted to the facility in August 2023, and discharged on September 26, 2024. R2's diagnoses included schizoaffective disorder. R2's Service Plan dated August 10, 2022, indicated R2 received services including medication administration. On February 11, 2025, at 1:10 p.m., assisted living director in residency (ALDIR)-B and clinical nurse supervisor (CNS)-A stated the discharge summary lacked the above required content, and the former assisted living director informed them a discharge assessment had not been completed as noted. In addition, CNS-A stated the format utilized lacked the required content. The licensee's Content of Resident Records policy dated September 15, 2022, noted the record would include a discharge summary including the resident's status at the time of discharge. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the	0 775		

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	28803	A. BUILDING: _____ B. WING _____	02/12/2025

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0 775	Continued From page 36 State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with Minnesota State Fire Code under Minnesota Rule Chapter 7511. The deficient condition has the ability to affect all 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 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on February 12, 2025, between 9:00 a.m. and 11:30 a.m. with assisted living director in residency (ALDIR)-B, the following condition was observed: UNOCCUPIED RESIDENT ROOM EMERGENCY ESCAPE OPENING: Resident sleeping room 1 emergency escape and rescue clear window opening measurements is 23" wide X 17" high X 31" windowsill height. This resident room is on the upper level of the facility. The window does not meet the 20 inches minimum requirements for height nor the 648 square inch clear opening. The window was measured by the surveyor with the ALDIR-B present. This window was replaced without a	0 775		

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0 775	Continued From page 37 permit on August 9, 2022. At least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. The windowsill height from the floor to the clear opening shall be not more than 48 inches. LOCKING: The surveyor observed a hasp lock as well as a cable lock on the 2nd floor marked exit door. This door shall always be openable without any special knowledge or tool. CARBON MONOXIDE: The surveyor did not observe carbon monoxide protection in the building. Carbon monoxide protection shall be provided within 10 feet of all sleeping areas. ELECTRICAL: The surveyor observed an open space in the main electrical panel, a cover missing on the well pump contactor and an open electrical receptacle on the ceiling in the lower level. All electrical boxes/connections shall have a cover on them.	0 775		

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0 775	Continued From page 38 SMOKING: The surveyor observed a plastic coffee container being used to dispose cigarette butts on the deck. A code complaint receptacle shall be provided and used for the discarding of cigarette butts. MEANS OF EGRESS: The surveyor observed snow blocking the east and south exit doors/deck/steps/ramp. Exit doors shall always be openable, snow shall be removed in a timely manner. DRYER VENT/LINT: The surveyor observed excessive lint accumulation behind the clothes dryer. The dryer was not ducted to the outside. The dryer shall be ducted outside using hard ducting with no screws in the elbows or joints and the area behind the dryer cleaned up. SEPARATION: The surveyor observed a window in the door between the garage and the facility. The garage is used to park vehicles and store gas fired equipment. A fire rated door is required between the home and the garage. These deficient conditions were visually verified by the ALDIR-B on the tour. TIME PERIOD FOR CORRECTION: Seven (7)	0 775		

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0 775	Continued From page 39 days.	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. Also, there were a few smoke alarms missing. These deficient conditions had the ability to affect all staff and residents.	0 780		

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0 780	Continued From page 40 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on February 12, 2025, between 9:00 a.m. and 11:30 a.m. with assisted living director in residency (ALDIR)-B, the following condition was observed: The surveyor observed when the smoke alarms were push button tested by the ALDIR-B, none of the smoke alarms operated in the facility including the one that was being tested. All the smoke alarms in the facility where not interconnected. Also, there was a smoke alarm missing in resident room 4 and the lower level and the alarm outside resident room 5 was hanging from is bracket and not secured. These alarms shall be interconnected to the rest of the alarms in the facility. Where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate and that smoke alarms are required inside all resident rooms, outside all resident rooms and on all levels of the facility.	0 780		

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0 780	Continued From page 41 The deficient condition was visually verified by the ALDIR-B accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, 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 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 potential to affect a large portion or all of the residents). The findings include:	0 790		

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0 790	Continued From page 42 On a facility tour on February 12, 2025, between 9:00 a.m. and 11:30 a.m. with assisted living director in residency (ALDIR)-B, the following condition was observed: The surveyor observed the fire extinguisher in the facility last had the required annual inspection completed in October 2022. It was also discharged, not in the green level on the gauge. Fire extinguishers shall be serviced annually by a competent person. The deficient condition was visually verified by the ALDIR-B on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and	0 800		

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0 800	Continued From page 43 well-being of the residents. This had the potential to directly affect all 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 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 on February 12, 2025, between 9:00 a.m. and 11:30 a.m. with assisted living director in residency (ALDIR)-B, the following condition was observed: The surveyor observed water stains and mold on the ceiling in the storage closet by the bathroom by the west exit door. The surveyor observed ceiling damage in the living room. The surveyor observed the bathroom by the west exit door fan did not operate and the cover and light bulb were missing. The facility shall be always kept in good repair. The deficient conditions were visually verified by the ALDIR-B accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 800		

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0 810	Continued From page 44	0 810		
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) staff 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) Staff 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 staff 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 the fire	0 810		

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	28803	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 810	Continued From page 45 safety and evacuation plan with the required content and the licensee failed to document required fire safety evacuation training for employees and residents as well as the required fire drills. This had the potential to directly affect all 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) 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: A record review and interview were conducted on February 12, 2025, at approximately 11:00 a.m. with assisted living director in residency (ALDIR)-B on the fire safety and evacuation plan for the facility, fire drills and training records for the employees and residents. FIRE/EVACUATION PLAN: Record review indicated the fire safety and evacuation plan shall be updated. It was last updated in October 2023. The plan did not have the facility floor plan inserted in it, was not accessible, did not show resident movement or capabilities. The plan was generic. TRAINING: Record review indicated the licensee failed to complete and document fire safety and evacuation training for the employees at a minimum of twice a year and offer the residents	0 810		

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	28803	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 810	Continued From page 46 the training at least once a year. FIRE DRILLS: Record review indicated that two fire drills were completed and documented in 2024. They are required to be completed two times per year on each shift and documented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative	0 900		

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	28803	A. BUILDING: _____ B. WING _____	02/12/2025

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0 900	Continued From page 47 according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide to the Office of Ombudsman for Long-Term Care (OOLTC) a complete unsigned copy of its contract. 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: On February 7, 2025, at 8:10 a.m., OOLTC stated they had requested a contract from the facility but had not received one. On February 12, 2025, at 10:35 a.m., assisted living director in residency (ALDIR)-B stated she did not believe the contract had been provided to the OOLTC as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		

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0 910	Continued From page 48	0 910		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification 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: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R4). 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: R4's start of services was December 13, 2024. R4's Service Agreement, identified as the contract, was signed by R4 on December 13, 2024. The licensee lacked a written contract with the	0 910		

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	28803	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 910	Continued From page 49 following required content: - the contract must include in a conspicuous place and manner the health facility identification (HFID) number; and - the name, telephone number, and physical mailing address of the licensee of the facility. On February 12, 2025, at 10:35 a.m., assisted living director in residency (ALDIR)-B stated the same contract template was utilized for all residents except for R1, who had an older version, and the contract lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) 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;	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

(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 50 (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an emergency relocation; (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 by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R4). 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 the potential to affect a large portion or all the residents). The findings include: R4's start of services was December 13, 2024. R4's Service Agreement, identified as the contract, was signed by R4 on December 13, 2024. The licensee lacked a written contract with the following required content: - a disclosure that it does not hold an assisted living facility with dementia care license: - 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	0 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

(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 51 the contract; and - a disclosure of the facility's ability to provide specialized diets. On February 12, 2025, at 10:35 a.m., assisted living director in residency (ALDIR)-B stated the same contract template was utilized for all residents except for R1, who had an older version, and the contract lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) 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	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 930	Continued From page 52 unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R4). 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 the potential to affect a large portion or all the residents). The findings include: R4's start of services was December 13, 2024. R4's Service Agreement, identified as the contract, was signed by R4 on December 13, 2024. The licensee lacked a written contract with the following required 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 which resident consent is required for a transfer; and - contact information for the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints. On February 12, 2025, at 10:35 a.m., assisted living director in residency (ALDIR)-B stated the same contract template was utilized for all	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

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0 930	Continued From page 53 residents except for R1, who had an older version, and the contract lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) 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	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

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0 940	Continued From page 54 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 interview and record review, the licensee failed to execute a written assisted living contract with the required content for one of one resident (R4). 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 the potential to affect a large portion or all the residents). The findings include: R4's start of services was December 13, 2024. R4's Service Agreement, identified as the contract, was signed by R4 on December 13, 2024. The licensee lacked a written contract with the following required content: - whether there was a limit on the number of people residing at the facility who could receive customized living services or participate in the housing support program, and if so, the limit must be provided;	0 940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 940	Continued From page 55 - 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 plan; and - 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. On February 12, 2025, at 10:35 a.m., assisted living director in residency (ALDIR)-B stated the same contract template was utilized for all residents except for R1, who had an older version, and the contract lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
0 950 SS=C	144G.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.	0 950		

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0 950	Continued From page 56 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 ensure one of one resident's (R4) assisted living contract included a notice with the required verbiage for the residents to identify a designated representative. 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:	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 950	Continued From page 57 R4's start of services was December 13, 2024. R4's Service Agreement, identified as the contract, was signed by R4 on December 13, 2024. R4's contract lacked the following required verbatim notice: "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." On February 12, 2025, at 10:35 a.m., assisted living director in residency (ALDIR)-B stated the same contract template was utilized for all residents except for R1, who had an older version, and the contract lacked the above required content. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn	01370		

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01370	Continued From page 58 (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices.	01370		

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01370	Continued From page 59 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of one unlicensed personnel (ULP-E). 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: ULP-E was hired on July 1, 2024, to provide direct care services to residents of the facility. ULP-E's employee record lacked documented evidence of the following required training/competency testing: - reports of changes in the resident's condition to the supervisor designated by the assisted living provider; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and assistance with dressing and toileting; - training on the prevention of falls for providers working with elderly or individuals at risk of falls; - standby assistance techniques and how to perform them; - basic nutrition, meal preparation, food safety,	01370		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

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01370	Continued From page 60 and assistance with eating; - preparation of modified diets as ordered by a licensed health professional- understanding appropriate boundaries between staff and residents and the resident's family; - procedures to utilize in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On February 12, 2025, at 11:40 a.m., assisted living director in residency (ALDIR)-B and clinical nurse supervisor (CNS)-A stated the training and competency testing had been completed by the prior licensed assisted living director/CNS, and they were unable to find any documented evidence of the training for ULP-E or verify it had been completed. The licensee's Training and Competency policy dated September 15, 2022, noted the ULP would meet all orientation and training requirements and be determined competent to perform all tasks by the registered nurse or other licensed health professional before they may provide any services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

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01380	Continued From page 61 resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for one of one unlicensed personnel (ULP-E). 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: ULP-E was hired on July 1, 2024, to provide direct care services to residents of the facility. ULP-E's employee record lacked documented evidence of the following required training/competency testing:	01380		

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01380	Continued From page 62 - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the resident; - recognizing physical, emotional, cognitive, and developmental needs of the resident; - safe transfer techniques and ambulation; and - range of motion and positioning; - administering treatments as required. On February 12, 2025, at 11:40 a.m., assisted living director in residency (ALDIR)-B and clinical nurse supervisor (CNS)-A stated the training and competency testing had been completed by the prior licensed assisted living director/CNS, and they were unable to find any documented evidence of the training for ULP-E or to verify it had been completed. The licensee's Training and Competency policy dated September 15, 2022, noted the ULP would meet all orientation and training requirements and be determined competent to perform all tasks by the registered nurse or other licensed health professional before they may provide any services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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01440	Continued From page 63 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual began working for the licensee for one of one unlicensed personnel, (ULP)-E. 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	01440		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

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01440	Continued From page 64 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on July 1, 2024, to provide direct care services to residents of the facility. ULP-E's employee record lacked documented evidence of a supervision of performing delegated tasks within 30 calendar days. On February 12, 2025, at 11:40 a.m., assisted living director in residency (ALDIR)-B and clinical nurse supervisor (CNS)-A stated they were unable to find evidence of a supervision being completed by the former licensed assisted living director/CNS, and were not aware if it had been completed or not. The licensee's Supervision of Licensed and Unlicensed Personnel policy dated September 15, 2022, noted director supervision of unlicensed staff performing delegated nursing tasks must be performed within 30 days after the person began working and had been trained and determined competent to perform all tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and	01460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

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01460	Continued From page 65 regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for one of one employee (clinical nurse supervisor/CNS-A).	01460		

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	28803	A. BUILDING: _____ B. WING _____	02/12/2025

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01460	Continued From page 66 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: CNS-A was hired on October 23, 2024, to provide direct care services to residents of the facility. CNS-A's employee record lacked documented evidence of the following: - an overview of the Assisted Living statutes; - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; - handling emergencies and using emergency services; - reporting maltreatment of vulnerable adults or minors; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Offices of the Ombudsman for Mental Health and Developmental disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01460		

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	28803	A. BUILDING: _____ B. WING _____	02/12/2025

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01460	Continued From page 67 other relevant advocacy services; - a review of the types of assisted living services the employee would be providing and the facility's category of licensure; and - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On February 12, 2025, at 11:25 a.m., CNS-A stated the required orientation had not been provided to her upon hire. The licensee's Assisted Living Orientation policy dated September 15, 2022, noted all employees must complete their orientation to assisted living requirements before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff	01470		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01470	Continued From page 68 responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication	01470		

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01470	Continued From page 69 access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living requirements and regulations prior to providing services for one of one employee (unlicensed personnel/ULP-E). 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: ULP-E was hired on July 1, 2024, to provide direct care services to residents of the facility. ULP-E's employee record lacked documented evidence of the following required orientation: - overview of the Assisted Living statutes; and - handling emergencies and using emergency services. On February 12, 2025, at 11:40 a.m., assisted living director in residency (ALDIR)-B and clinical nurse supervisor (CNS)-A stated the orientation had been completed by the previous licensed assisted living director/CNS. ALDIR-B stated she was not aware if statutes were reviewed or not,	01470		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01470	Continued From page 70 and was not able to provide any documentation. The licensee's Assisted Living Orientation policy dated September 15, 2022, noted orientation must include an overview of the statutes and handling emergencies and use of emergency services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01500	Continued From page 71 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel/ULP-D).	01500		

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	28803	A. BUILDING: _____ B. WING _____	02/12/2025

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01500	Continued From page 72 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D was hired on March 25, 2020, to provide direct care services to residents of the facility. On February 11, 2025, from 7:35 a.m. through 7:45 a.m., ULP-D was observed to administer medications to residents. ULP-D's employee record lacked documented evidence of at least eight hours annual training for every 12 months of employment in the following topics: - reporting maltreatment of vulnerable adults; - Assisted Living Bill of Rights; - infection control techniques; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; - review of provider's policies and procedures; and - principles of person-centered planning/service delivery. On February 12, 2025, at 11:55 a.m., assisted living director in residency (ALDIR)-B and clinical nurse supervisor (CNS)-A stated annual training had not been provided to any staff including the	01500		

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	28803	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

(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
01500	Continued From page 73 required topics. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	01530		

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	28803	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

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01530	Continued From page 74 Based on observation, interview, and record review, the licensee failed to ensure three of three employees (clinical nurse supervisor/CNS-A, unlicensed personnel/ULP-E, ULP-D) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had a current assisted living facility with dementia care license. CNS-A CNS-A was hired on October 23, 2024, to provide direct care services to residents of the facility. CNS-A's employee record lacked evidence CNS-A had completed the required eight hours of initial training within 120 working hours. ULP-E ULP-E was hired on July 1, 2024, to provide direct care services to residents of the facility. ULP-E's employee record lacked evidence ULP-E had completed the required eight hours of initial training within 160 working hours. ULP-D ULP-D was hired on March 25, 2020, to provide	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

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01530	Continued From page 75 direct care services to residents of the facility. On February 11, 2025, from 7:35 a.m. through 7:45 a.m., ULP-D was observed to administer medications to residents. ULP-D's employee record lacked evidence ULP-D had completed the required two hours of training on topics related to dementia for each 12 months employment. On February 12, 2025, at 11:40 a.m., assisted living director in residency (ALDIR)-B and CNS-A stated dementia training was not being provided to any employees and they were not aware of the requirement to do so. CNS-A stated she had completed Teepa Snow training, but it was greater than 18 months prior to employment with the licensee. The licensee's Dementia Training and Disclosure Requirements (for facilities that serve persons with dementia - not part of a specialized memory care program) policy dated September 15, 2022, noted the licensee provided required dementia training to all direct care staff and supervisors, and the registered nurse developed appropriate training materials. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of	01560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

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01560	Continued From page 76 previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who requested it, a complete description of the dementia care training program to include the required content. 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: The licensee provided services under an assisted living license. The licensee's Dementia Training and Disclosure	01560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01560	Continued From page 77 Requirements (for facilities that serve persons with dementia - not part of a specialized memory care program) policy dated September 15, 2022, noted "The Assisted Living Director develops a written statement called 'Dementia Training Disclosure' that is available to residents, the residents' representatives and families upon their request. The Dementia Training Disclosure describes our facility's training program and any related training, and covers at least the following topics: a. Categories of employees trained; b. Frequency of training; and c. Basic topics covered by the training." On February 11, 2025, assisted living director in residency (ALDIR)-B stated she texted the former licensed assisted living director/CNS to ask about this form. However, no further information was received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01560		
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	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

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01620	Continued From page 78 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 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 observation, interview, and record review, the licensee failed to ensure all areas of the uniform assessment tool as required per Minnesota Administrative Rule 4659.0150 were addressed for one of one resident (R1) and failed to ensure the registered nurse (RN) completed a comprehensive reassessment not to exceed 90 days, as required, for one of one resident (R1). In addition, the licensee failed to complete a comprehensive assessment to include an assessment of current smoking status for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	01620		

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01620	Continued From page 79 COMPREHENSIVE ASSESSMENT R1's diagnoses included seizures, depression, and developmental disability. Throughout the survey, R1 was observed in the living room watching TV. R1's Service Plan dated August 10, 2022, noted R1 received services including medication administration, and assistance with room cleaning. R1's record contained the following assessments: - Skilled Observation/Assessment dated June 2, 2023; - Skilled Observation/Assessment dated September 2, 2023; and - RN Baseline Assessment Form dated January 8, 2025 (greater than 90 days after the last assessment). R1's assessment lacked the following required content: - a review of medications according to Minnesota (MN) statutes, section 144G.71, Subd. 2, including the reason taken, any side effects, contraindications, allergic or adverse reactions, and actions to address those issues, dosage, frequency of use, route administered, and any difficulties the resident faces in taking the medication; - a review of medical, dental, and emergency room visits in the past 12 months; - a review of physical therapy, occupational therapy, speech therapy, or cognitive evaluations within the past 12 months; - list of treatments, including type, frequency, and level of assistance needed;	01620		

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01620	Continued From page 80 - risk factors; and - the need for follow-up referrals for additional medical or cognitive care by health professionals. On February 11, 2025, at 12:25 p.m., assisted living director in residency (ALDIR)-B and clinical nurse supervisor (CNS)-A stated the above content was not included on either assessment documents utilized by the licensee. In addition, CNS-A stated she had only completed one assessment for R1, and was told the assessments were all up-to-date by the previous licensed assisted living director/CNS when she started. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. The licensee's Initial and Ongoing Nursing Assessment of Residents policy dated September 15, 2022, noted the assessment must not exceed 90 days from the date of the last	01620		

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01620	Continued From page 81 assessment. SMOKING On February 11, 2025, the surveyor observed R3 come to the dining room, get a cigarette from unlicensed personnel (ULP)-D, and go outside on the deck to smoke. R3's diagnoses included hypertension. R3's Service Plan dated August 1, 2022, indicated R3 received services including behavior monitoring and medication administration. R3's undated RN Baseline Assessment Form lacked any information on smoking. On February 11, 2025, at 11:15 a.m., CNS-A stated there was no smoking assessment for R3. In addition, CNS-A stated she would complete a smoking assessment if there was a new resident who smoked, but not every 90 days. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0150, Subp. 2, effective October 2022, a nursing assessment must address risk indicators, including smoking and the ability to smoke without causing burns or injury to the resident or others or damage to property. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640		

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01640	Continued From page 82 that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the resident to document agreement on the services to be provided for one of three residents (R2). 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).	01640		

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01640	Continued From page 83 The findings include: R2's diagnoses included schizoaffective disorder. R2's Service Plan dated August 10, 2022, included a signature of the former licensed assisted living director/clinical nurse supervisor. However, it lacked a signature or other authentication by the resident documenting agreement on the services to be provided. On February 11, 2025, at 1:10 p.m., assisted living director in residency (ALDIR)-B stated the service plan lacked a signature by the resident, and stated at times they have difficulty getting a signature from the residents' representatives. The licensee's Contents of Service Plans policy dated September 15, 2022, noted "The service plan is revised and signed by the registered nurse and/or other licensed health professional and the resident and/or the resident's representative any time assisted living services change based on changes in the resident's needs or preferences and any time our facility's fee schedule changes." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;	01650		

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01650	Continued From page 84 (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R1). 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).	01650		

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01650	Continued From page 85 The findings include: R1's diagnoses included seizures, depression, and developmental disability. Throughout the survey, R1 was observed in the living room watching TV. R1's Service Plan dated August 10, 2022, noted R1 received services including medication administration, and assistance with room cleaning. However, it lacked: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; - a contingency plan including: - information as to who has the authority to sign for the resident in an emergency; and - the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On February 11, 2025, at 12:25 p.m., assisted living director in residency (ALDIR)-B and clinical nurse supervisor (CNS)-A stated the same template was utilized for all residents, and the service plan lacked the above required content. The licensee's Content of Service Plans dated September 15, 2022, noted the service plan would include the schedule and methods of monitoring reviews or reassessments of the resident, the frequency of supervision of staff providing services and the identification of supervisors who would be providing the supervision, and a contingency plan including the	01650		

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01650	Continued From page 86 identification of who had the authority to sign in an emergency and the circumstances in which emergency medical services were not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of	01700		

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01700	Continued From page 87 medications. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of one resident (R1) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on February 10, 2025, at 9:15 a.m., assisted living director in residency (ALDIR)-B stated the licensee provided medication management services to residents at the facility. R1's diagnoses included seizures, depression, and developmental disability. Throughout the survey, R1 was observed in the living room watching TV. R1's Service Plan dated August 10, 2022, noted R1 received services including medication administration, and assistance with room cleaning.	01700		

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01700	Continued From page 88 R1's prescriber orders dated June 3, 2024, included two seizure medications and an antidepressant. R1's RN Baseline Assessment Form dated January 8, 2025, lacked an assessment to include: - an identification and review of all medications the resident is known to be taking; - indications for medications; - side effects; - contraindications; - allergic or adverse reactions; and - actions to address these issues. R1's Medication/Treatment Record for February 2025, listed medications as prescribed, times to administer, and staff initials through February 11, 2025, to indicate the medications had been administered. On February 11, 2025, at 12:25 p.m., ALDIR-B and clinical nurse supervisor (CNS)-A stated the above required information was not included on the assessment forms being utilized for all residents. The licensee's Initial and Ongoing Nursing Assessment of Residents policy dated September 15, 2022, noted an assessment of the resident's need for medication must be conducted face-to-face and include identification and review of all medications the resident was known to be taking, indications for medications, side effects, contraindications, allergic or adverse reactions and actions to address the issues. No further information was provided.	01700		

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01700	Continued From page 89 TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled;	01790		

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01790	Continued From page 90 (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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	01790		

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CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

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01790	Continued From page 91 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 10, 2025, at 9:15 a.m., assisted living director in residency (ALDIR)-B stated the licensee provided medication management services to residents at the facility. The licensee lacked written procedures to include: - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; - how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; - how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; - a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and - how the unlicensed personnel must document in	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

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01790	Continued From page 92 the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. The licensee's undated Medications for a Resident Who Will Be Away From the Facility When Medications Are Schedule policy dated September 15, 2025, noted for unplanned time away when the licensed nurse was not available, the RN would develop written procedures for the unlicensed staff to follow. On February 11, 2025, at 1:25 p.m., clinical nurse supervisor (CNS)-A stated written procedures were not available, and only had a note on how staff were to label the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of one resident (R1). This practice resulted in a level two violation (a	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

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01820	Continued From page 93 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on February 10, 2025, at 9:15 a.m., assisted living director in residency (ALDIR)-B stated the licensee provided medication management services to residents at the facility. R1's record lacked signed prescriber orders. R1's diagnoses included seizures, depression, and developmental disability. Throughout the survey, R1 was observed in the living room watching TV. R1's Service Plan dated August 10, 2022, noted R1 received services including medication administration, and assistance with room cleaning. R1's After Visit Summary dated June 3, 2024, identified as the current prescriber orders, included two supplements and two antidepressants. However, it lacked a prescriber's signature. On February 11, 2025, at 12:25 p.m., ALDIR-B and clinical nurse supervisor (CNS)-A stated R1 lacked signed prescriber orders.	01820		

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	28803	A. BUILDING: _____ B. WING _____	02/12/2025

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01820	Continued From page 94 The licensee's Content of Medication Prescriptions and Treatment or Therapy Orders dated September 15, 2022, noted medication prescriptions must include the prescriber's manual or electronic signature. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were secure and permitted access to only authorized personnel for one of one medication cart. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28803	A. BUILDING: _____ B. WING _____	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

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01880	Continued From page 95 During the entrance conference on February 10, 2025, at 9:15 a.m., assisted living director in residency (ALDIR)-B stated the licensee provided medication management services to the residents at the facility. On February 11, 2025, at 6:55 a.m., the surveyor observed unlicensed personnel (ULP)-D and ULP-E at shift exchange, where oral report was given, and the medication cart was observed to be unlocked. At 9:12 a.m., the surveyor observed ULP-D take medications and breakfast to a resident in her room, and returned at 9:21 a.m. The medication cart remained unlocked during this time, with R1 in the living room adjacent to the dining room with the medication cart. At this time, the surveyor observed with ULP-D, the medication cart keys in the top drawer of the medication cart, and ULP-D stated the lock had not been working right for a few weeks, and ALDIR-B was aware. ULP-D stated she was scared if the cart was locked it would not be able to be unlocked. On February 11, 2025, at 10:00 a.m., ALDIR-B stated the medication cart should be locked, and stated she was aware it was sticking. In addition, ALDIR-B stated last month a locksmith had been out to look at it and a new mechanism needed to be ordered. The licensee's Storage of Medications policy dated September 15, 2022, noted all resident medications would be stored in a locked medication cart. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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	28803	A. BUILDING: _____ B. WING _____	02/12/2025

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CEDAR COVE ASSISTED LIVING	21596 CEDAR LAKE ROAD SAUK CENTRE, MN 56378

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01900 SS=F	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure no prescription drug supply for one resident was saved for use by anyone other than the resident. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On February 11, 2025, at 10:15 a.m., the surveyor observed the medication cart with unlicensed personnel (ULP)-D, which included an unopened bottle of Pepto Bismol, two opened containers of Tums, two opened containers of acetaminophen 500 milligrams (mg), and one opened container of ibuprofen 200 mg. At this time, ULP-D stated these medications could be used for any resident if needed. In addition, ULP-D stated the Pepto Bismol was for staff use. On February 11, 2025, at 11:25 a.m., assisted living director in residency (ALDIR)-B and clinical nurse supervisor (CNS)-A stated no standing orders were available for the above stock medications, and staff medications should not be	01900		

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01900	Continued From page 97 kept in the medication cart. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R2) upon discharge.	01910		

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01910	Continued From page 98 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 discharged on September 26, 2024. R2's diagnoses included schizoaffective disorder. R2's record included a Transfer/Discharge Summary dated September 26, 2024, which noted R2 moved to another assisted living facility. However, it lacked a disposition of medications to include: - the medication name; - strength; - prescription number as applicable; - quantity; - to whom the medications were given; - date of disposition; and - names of staff and other individuals involved in the disposition. R2's Service Plan dated August 10, 2022, indicated R2 received services including medication administration. On February 11, 2025, at 1:10 p.m., assisted living director in residency (ALDIR)-B and clinical nurse supervisor (CNS)-A stated a medication disposition with the required content had not been completed, and stated they were not aware of the requirement to do so.	01910		

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01910	Continued From page 99 The licensee's Disposition or Disposal of Medication policy dated September 15, 2022, noted documentation of the destruction of medications would include the date, quantity, name, prescription number, signature of the person destroying the drugs and signature of the witness would be documented in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that one person who was responsible for responding to the requests of residents for assistance with health or safety needs was awake at night. 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	02320		

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02320	Continued From page 100 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on February 10, 2025, at 9:15 a.m., assisted living director in residency (ALDIR)-B stated the licensee scheduled 8 and 16 hour shifts, depending on the day, and stated one unlicensed personnel (ULP) was scheduled per shift. On February 11, 2025, at 6:45 a.m., the surveyor entered the facility and found ULP-E awake working alone on the night shift. ULP-E stated she had worked there a few months and could sleep or be awake on the night shift. ULP-E stated she set an alarm for every hour on the night shift because she would doze off. ULP-E stated she was told it was ok to do this when she was hired. On February 11, 2025, at 1:15 p.m., ALDIR-B stated staff are expected to be awake on the night shift, and it was not acceptable to be sleeping. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health
Environmental Health Division
3333 W. Division #212
St. Cloud
320-223-7300

Type: Full
Date: *02/10/25*
Time: 11:15:43
Report: 1041251035

Food and Beverage Establishment Inspection Report

Location:
Cedar Cove Assisted Living
21596 Cedar Lake Road
Sauk Centre, MN56378
Stearns County, 73

Establishment Info:
ID #: 0037551
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3207321939
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 previously issued on 07/25/22 have NOT been corrected.

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

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

PROVIDE CHLORINE TEST STRIPS FOR BLEACH SANITIZER THAT IS USED FOR FOOD CONTACT SURFACES
2/10/25 SAME.

Issued on: 07/25/22 *Comply By: 07/25/22*

The following orders were issued during this inspection.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

KARMEN UECKER HAS PASSED A FOOD SAFETY COURSE, BUT DID NOT APPLY FOR THE STATE CERTIFICATE. SHE WILL NEED TO RETAKE THE FOOD SAFETY COURSE AND APPLY FOR THE STATE CERTIFICATE WITHIN 6 MONTHS OF PASSING THE COURSE.

Comply By: 03/31/25

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

AT TIME OF INSPECTION, THE DISHWASHER WAS OUT OF ORDER. REPAIR OR REPLACE THE DISHWASHER. SANITIZE DISHES IN THE SINK UNTIL DISHWASHER IS REPAIRED.

Comply By: 03/10/25

Food and Equipment Temperatures

Type: Full
Date: *02/10/25*
Time: 11:15:43
Report: 1041251035
Cedar Cove Assisted Living

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: MILK
Violation Issued: No

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

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 1041251035 of 02/10/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /_____

Signed:_____
Establishment Representative

Signed: Linda Heinen

Linda Heinen
Public Health Sanitarian
St. Cloud
320-223-7306
Linda.Heinen@state.mn.us