Electronically Delivered

October 16, 2025

Licensee
Boulder Creek
604 Village Drive
Marshall, MN 56258

RE: Project Number(s) SL30908016

Dear Licensee:

On September 30, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on June 26, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

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August 18, 2025

Licensee
Boulder Creek
604 Village Drive
Marshall, MN 56258

RE: Project Number(s) SL30908016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 26, 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 . . ."

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 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00
St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $9,500.00**. 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 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

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

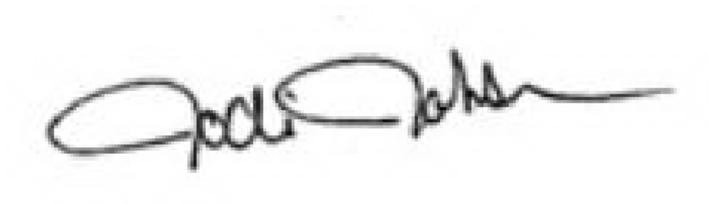
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30908	A. BUILDING: _____ B. WING _____	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULDER CREEK	604 VILLAGE DRIVE MARSHALL, MN 56258

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30908016-0 On June 23, 2025, through June 26, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 25 residents; 25 receiving services under the Assisted Living Facility with Dementia Care license. 1290: An immediate correction order was identified on June 23, 2025, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remains at I. 2070: An immediate correction order was identified on June 26, 2025, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remains at I.	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.	

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0 000	Continued From page 1 2310: An immediate correction order was identified on June 24, 2025, at a level 3/Widespread (I). The licensee took immediate action; however, the scope and level remains at I.	0 000		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. 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 the potential to affect a large portion or all of the residents). The findings include: During facility tour on June 23, 2025, from 11:32 a.m. through 12:34 p.m., with licensed assisted living director (LALD)-A, executive director (ED)-D and maintenance supervisor (MS)-C the surveyor observed that carbon monoxide alarms or detectors were not provided in the facility. MS-C stated that the detectors located in the mechanical rooms were smoke detectors and the	0 775		

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0 775	Continued From page 2 alarms in the resident rooms were smoke alarms. State Fire Code in Minnesota Rules, chapter 7511 requires either; rooms that contain a fuel burning appliance be equipped with a carbon monoxide detection system, or carbon monoxide alarms be located within ten feet of every sleeping room. During an interview on June 23, 2025, at 1:37 p.m. with LALD-A, ED-D and MS-C the surveyor requested a copy of the annual fire alarm testing and inspection report. LALD-A provided the surveyor a copy of the kitchen hood fire suppression inspection report and an invoice for fire extinguisher testing. During the interview ED-D called the company that conducted the building sprinkler and kitchen hood inspections and asked if they had also completed the fire alarm testing and inspection. While on the phone, the company stated that they had not completed the annual fire alarm system inspection and testing. ED-D stated they did not have a report and did not know if the facility has ever had the fire alarm system tested. State Fire Code in Minnesota Rules, chapter 7511 requires fire alarm systems be inspected and tested at least annually. LALD-A, ED-D and MS-C verified the above findings and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to	01290		

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01290	Continued From page 3 the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted through Department of Human Services (DHS) NETStudy 2.0 and received in affiliation with the assisted living license for one of one employee (maintenance (M)-H). In addition, the licensee failed to ensure a background study was affiliated with this licensee's health facility identification (HFID) 30908 for one of one employee (registered nurse (RN)-I). This resulted in an immediate order on June 23, 2025. This practice resulted in a level three violation (a violation that harmed a client/resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 the residents).	01290		

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01290	Continued From page 4 The findings include: M-H The licensee's NETStudy roster printed on June 23, 2025, indicated M-H had COVID-19 study expired on December 31, 2022. On June 23, 2025, at 2:14 p.m., executive director (ED)-D stated M-H rarely works anymore, M-H was going to retire but still works "some." RN-I During the entrance conference on June 23, 2025, at approximately 3:30 p.m., clinical nurse supervisor (CNS)-B stated RN-I worked casually for the provider. RN-I was licensed as a nurse on June 21, 2017. RN-I was listed on DHS NETStudy 2.0 as "affiliated" on February 8, 2022, and had a separation date of November 15, 2022, for the licensee's HFID 30908. RN-I was currently affiliated with the licensee's sister facility HFID 20507. On June 23, 2025, at 5:00 p.m., licensed assisted living director (LALD)-A stated all staff should have had cleared background studies and ED-D is working on running new background studies for M-H and RN-I. ED-D further stated it was possible they seperated RN-I from the wrong HFID. At 5:16 p.m., LALD-A further stated RN-I could potentially have unsupervised contact with residents while working. The licensee's Background Checks policy July 29, 2021, indicated All employees; as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will	01290		

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01290	Continued From page 5 undergo a background study through DHS. Only those with satisfactory results will continue to work with the facility and its residents. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The licensee took immediate action to mitigate the identified risk. Scope and level remains at I.	01290		
01360 SS=F	144G.61 Subdivision 1 Instructor and competency evaluation requirem Instructors and competency evaluators must meet the following requirements: (1) training and competency evaluations of unlicensed personnel who only provide assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), must be conducted by individuals with work experience and training in providing these services; and (2) training and competency evaluations of unlicensed personnel providing assisted living services must be conducted by a registered nurse, or another instructor may provide training in conjunction with the registered nurse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations of unlicensed personnel providing assisted living services were conducted by a registered nurse (RN) for one of two unlicensed personnel (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01360		

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01360	Continued From page 6 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: ULP-E ULP-E was hired on December 2, 2022, to provide direct care and services to the licensee's residents. On June 23, 2025, at 11:31 a.m., the surveyor observed ULP-E checking blood sugar and administering medication to a resident. ULP-E's employee record indicated competency testing was completed for the following by a licensed practical nurse (LPN) and not a RN as required: - Medication administration - all routes - Oxygen use - Lifting and safe transfers - Compression stockings - CPAP (continuous positive airway pressure) On June 25, 2025, at 12:55 p.m., clinical nurse supervisor (CNS)-B stated she was unaware ULP-E's competencies had been completed by a LPN and not a RN, and was unaware the competencies must be completed by a RN. The licensee's Assisted Living Orientation - ULP Staff policy dated July 29, 2021, indicated Training and competency evaluations of unlicensed personnel providing assisted living services will be completed by a registered nurse. Another instructor may provide training in	01360		

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01360	Continued From page 7 conjunction with a registered nurse. In addition to training all staff receive, ULPs who are a registered nursing assistant will receive additional training on the following topics with a written or oral competency test AND a skill demonstration. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01360		
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; (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	01370		

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01370	Continued From page 8 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 observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-E, ULP-L) completed training and competency evaluations in all required training topics. 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 ULP-E was hired on December 2, 2022, to provide direct care and services to the licensee's residents.	01370		

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01370	Continued From page 9 On June 23, 2025, at 11:31 a.m., the surveyor observed ULP-E checking blood sugar and administering medication to a resident. ULP-E's employee record lacked evidence of completed training and/or competency for 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; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care; (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; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; and (13) understanding appropriate boundaries between staff and residents and the resident's family. ULP-L ULP-L was hired on June 21, 2024, to provide direct care and services to the facility's residents. On June 24, 2025, at approximately 7:45 a.m., the surveyor observed ULP-L administering medications to a resident. ULP-L's record lacked evidence the following competency testing had been completed:	01370		

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01370	Continued From page 10 (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; and (7) standby assistance techniques and how to perform them. On June 25, 2025, at 12:55 p.m., clinical nurse supervisor (CNS)-B stated all training and competency testing documentation had been provided to the surveyor and staff should have had all of the required training and competency testing. The licensee's Assisted Living Orientation - ULP Staff dated July 29, 2021, indicated the the ULPs would be trained and/or competency tested in 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; (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; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; and (13) understanding appropriate boundaries	01370		

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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
01370	Continued From page 11 between staff and residents and the resident's family 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 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 observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP-E, ULP-L) completed training and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30908	A. BUILDING: _____ B. WING _____	06/26/2025

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01380	Continued From page 12 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 ULP-E was hired on December 2, 2022, to provide direct care and services to the licensee's residents. On June 23, 2025, at 11:31 a.m., the surveyor observed ULP-E checking blood sugar and administering medication to a resident. ULP-E's employee record lacked evidence of completed training and/or competency for the following: (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; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) ambulation; and (6) range of motioning and positioning. ULP-L ULP-L was hired on June 21, 2024, to provide direct care and services to the facility's residents. On June 24, 2025, at approximately 7:45 a.m.,	01380		

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01380	Continued From page 13 the surveyor observed ULP-L administering medications to a resident. ULP-L's record lacked evidence the following competency testing had been completed: - ambulation. On June 25, 2025, at 12:55 p.m., clinical nurse supervisor (CNS)-B stated all training and competency testing had been provided to the surveyor and staff should have had all of the required training and competency testing. The licensee's Assisted Living Orientation - ULP Staff dated July 29, 2021, indicated the the ULP's would be trained and/or competency tested in the following: (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; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; and (6) range of motioning and positioning No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01540 SS=D	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified	01540		

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01540	Continued From page 14 under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP-L) received the required amount of dementia care training within 80 working hours of employment. 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:	01540		

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01540	Continued From page 15 During the entrance conference on June 23, 2025, at 10:45 a.m., licensed assisted living director (LALD)-A stated the facility was split into two memory care units with a total of 25 residents receiving services. ULP-L was hired on June 21, 2024, to provide direct care and services to the licensee's residents. On June 24, 2025, at approximately 7:45 a.m., the surveyor observed ULP-L administering medications to a resident. ULP-L's employee file included the following dementia training: - July 8, 2024, - Dementia - Meaningful Engagement and Activities 0.5 hour - July 10, 2024, -Dementia - Communication Skills 0.75 hour. - July 10, 2024, - Dementia - Strategies and Communication Tips for ADL (activities of daily living) Care 0.75 hours - July 10, 2024 Dementia - Strategies and Communication Tips for Mealtime 0.5 hour - February 13, 2025, Dementia - Understanding Behavioral Symptoms 1 hour - February 24, 2025, Dementia End-of-Life Care 0.5 hour - February 24, 2025, Dementia - Person-Centered Care and Care Planning 0.5 hour - February 24, 2025, Dementia - Standards of Care 0.75 hour - February 24, 2025, Dementia - The Power of Reminiscing 0.5 hour ULP-L had 2.5 hours of dementia care training upon hire and a total of 5.75 hours completed since hire.	01540		

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01540	Continued From page 16 On June 25, 2025, at 12:55 p.m., clinical nurse supervisor (CNS)-B stated ULP-L worked full time hours, so ULP-L would have reached the 80 working hours within the first few weeks of employment and she should have had the required dementia training within the first 80 hours of employment. The licensee's Assisted Living Dementia Training dated June 9, 2022, indicated Direct-care staff will complete: 1. a minimum of 8 hours of initial training on dementia care topics 2. initial training will be completed within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24	02070		

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02070	Continued From page 17 hours a day, seven days a week, who were responsible for responding to requests of residents for assistance in secured dementia care (memory care) units. This had the potential to affect all residents. This resulted in an immediate correction order issued on June 26, 2025. 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 facility had an Assisted Living Facility with Dementia Care license effective August 1, 2021. On June 26, 2025, at 11:00 a.m., the surveyor toured the facility. The facility's layout consisted of two secured units (north and south) separated by the main entrance, a T-shaped hallway, offices, storage rooms, a meeting room and public restrooms. The main entrance was locked to people coming in but could be exited without restriction. Both of the secured units could be entered without restriction but required a badge to exit. On June 26, 2025, at 10:50 a.m., licensed assisted living director (LALD)-A stated there were currently 13 residents residing on the north side and 12 residents residing on the south side for a total census of 25 residents. On June 26, 2025, at 3:12 p.m., clinical nurse	02070		

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02070	Continued From page 18 supervisor (CNS)-B and LALD-A stated there was one unlicensed personnel (ULP) on each unit during the night. A requirement for the facility was that residents were either independent or only required one assist. If a resident fell and required assistance to get up or if for some other reason they needed two person assistance, the ULP's were to call the other ULP to come over and assist. Staff brought the phone with them, which linked to the pull cord system and mobility alarms so staff would be notified if a resident needed assist on their unit while they were helping on the other side. LALD-A further stated the staff have also called the fire department for lift assistance after a fall. On June 26, 2025, at 6:05 a.m. upon arrival at the facility, the surveyor called the staff phone to gain entrance to the facility. ULP-N came to the door and let the surveyor in and then returned to the south unit. ULP-N was working alone in the south unit, therefore, the unit was unattended during the time ULP-N came to let the surveyor into the building. On June 26, 2025, at 6:09 a.m., ULP-M stated during the night there was one staff assigned to each unit. If a fall were to occur, the staff would call the staff member on the other side to assist with getting the resident up, help with vital signs and make sure the resident was ok. This has happened a few times when she has been working. ULP-M stated the staff are to take the phone with them which links to the pull cord system and any mobility alarms a resident may have. If the phone alerted her, she would make sure the resident was ok with the other staff, return to her unit to assist the resident, and then go back to the other unit to finish helping if needed. ULP-M stated they would be off the unit	02070		

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02070	Continued From page 19 for a maximum of 15 minutes. On June 26, 2025, at 6:14 a.m., ULP-N stated staff had a thirty minute break but stayed on the unit in case a resident required assistance. If a resident were to fall, staff are to call the other side to come over and help get the resident up. ULP-N stated it had only happened one time since she started working here. If staff go to assist on the other side, they would be out of their assigned unit for a maximum of five minutes. ULP-N stated staff carries the phone with them that alerts them to any pull cords or pressure alarms. R6's Fall - Incident report dated February 11, 2025, at 2:00 a.m., identified R6 had fallen and ULP-N called the north aide to come over and assist in getting R6 up safely. R8's Fall - Incident report dated April 17, 2025, at 2:10 a.m., identified R8 had fallen and ULP-M called the north aide to come and assist in transferring the resident from the floor. The licensee's Direct-Care Staffing Plan dated May 21, 2025, indicated the following: The licensee was a secured dementia care unit and had the ability to serve 31 residents; · When residents require a two-person assist there will be a minimum of two staff available at all times. · There will be 24-hour, awake staff available to respond to resident requests for assistance with health and safety needs. Requirements for staff are available in the staffing policy. · Between the hours of 11:00 p.m. and 7:00 a.m. there will be direct-care staff able to respond to a resident's request for assistance with health and safety needs within a reasonable amount of time. These staff will be located in the same building in	02070		

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02070	Continued From page 20 order to respond within a reasonable amount of time. · Staffing schedules and daily postings will reflect the determination of what is needed for adequate number of staff. * 4- Home health aides 0645-1500 throughout the building * 4- Home health aide 1445-2300 throughout the building * 2-3 Home health aide 1045-0700 throughout the building The licensee's Staffing, Direct-Care Staffing Plan & Daily Schedule policy dated May 16, 2024, included the following: 2. Staffing: a. From the hours of 11:00 p.m. to 7:00 a.m., direct-care staff will respond to a resident request for assistance with health or safety needs within a reasonable amount of time. b. A minimum of two direct-care staff will be scheduled and available to assist at all times whenever a resident requires the assistance of two. c. One or more persons will be available 24-hours per day, seven days per week who are responsible for responding to the requests of residents for assistance for health and safety needs. Persons will be: i. Awake ii. Located in: 1. The same building -OR- 2. An attached building -OR- 3. On a contiguous campus within the facility in order to respond within a reasonable amount of time iii. Capable of communicating with residents iv. Capable of summoning appropriate assistance	02070		

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02070	Continued From page 21 v. Capable of following directions No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The license took immediate action to mitigate the identified risk. Scope and level remains at I.	02070		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for three of three residents (R5, R6, R7) with side rails. This resulted in an immediate order issued on June 24, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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:	02310		

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02310	Continued From page 22 R5 R5 was began receiving services on December 20, 2023. R5's diagnoses included vascular dementia with anxiety, arthritis, and macular degeneration. On June 24, 2025, at 7:49 a.m., the surveyor observed R5 laying in her bed sleeping with oxygen on. R5's bed had a U-shaped grab bar with bars on the bottom that went between the mattress and box spring. On June 24, 2025, at 8:57 a.m., the surveyor and clinical nurse supervisor (CNS)-B observed the grab bar. The grab bar was securely attached to a large board between the mattress and box spring. R5's Clinical Update Assessment dated April 28, 2025, indicated R5 had a standard bed frame with a mattress that was original to the bed. R5 had a "bed cane for bed mobility" and staff were to "notify nurse if bed cane is not secure to frame or railing/opening by bar is too big or doesn't fit regulation size". Risks and benefits had been discussed with the resident and family. R6 R6 began receiving services on April 19, 2024. R6's diagnoses included dementia, anxiety, degenerative joint disease, diabetes, and peripheral neuropathy. On June 24, 2025, at 8:39 a.m., the surveyor and unlicensed personnel (ULP)-G observed a large grab bar on R6's bed with bars that extended under the bed. The grab bar had four horizontal bars and two vertical bars at each end. The grab	02310		

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02310	Continued From page 23 bar easily slid out from under the bed and created approximately a six inch gap between the grab bar and the mattress. On June 24, 2025, at 9:26 a.m., the surveyor and CNS-B observed the grab bar with the above noted gap of approximately six inches. The grab bar was secured to the opposite side of the bed by straps, which were loose. CNS-B stated that could create a risk for entrapment and would have maintenance adjust the straps to secure it tightly to the mattress. R6's Clinical Update Assessment dated May 5, 2025, indicated R6 had a standard bed frame with a mattress that was original to the bed. R6 had a partial side rail installed as recommended by physical and occupational therapy. The side rail was used to aid R6 in transfers to and from the bed. The staff were to "notify nurse if bed cane is not secure to frame or railing/opening by bar is too big or doesn't fit regulation size". Risks and benefits had been discussed with the resident and family. R7 R7 was admitted under the licensee's Comprehensive Home Care license on February 15, 2021, and began receiving services under the Assisted Living License on August 1, 2021. R7's diagnoses included cognitive deficit after a stroke, and atrial fibrillation (irregular heart rate). On June 24, 2025, at 9:46 a.m., the surveyor observed R7's bed with CNS-B. R7's bed had a large U-shaped grab bar with bars that slid between the mattress and the box spring. The grab bar did not have anything securing it to the bed.	02310		

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02310	Continued From page 24 R7's Clinical Update Assessment dated June 16, 2025, indicated R7 had a standard bed frame with a mattress that was original to the bed and R7 had a bed cane as recommended by the occupational therapist for bed mobility. On June 24, 2025, 8:57 a.m., CNS-B stated she did not have manufacturer instructions for any of the grab bars, and she had not checked the Consumer Product Safety Commission (CSPC) for recalls. CNS-B stated she was unaware of the requirement. The licensee's undated Bed Rails and Bed Cane Education policy indicated the following: 1. Initial Assessment: Conduct a comprehensive assessment to determine the resident's cognitive and physical status, potential risk for entrapment or falls, and the intended purpose of the bed rail. 2. Ongoing Assessment: Reassess the resident's need for and safe use of bed rails whenever there is a change in condition or at least every 90 days. 3. Alternative Interventions: Explore and document attempts to use alternatives to bed rails to address the resident's needs. 4. Documentation: Document the purpose and intention of bed rail use, assessment results, risk/benefit discussion, and interventions offered or attempted. 2. Installation and Maintenance: 1. Correct Installation: Ensure bed rails are installed according to manufacturer's recommendations and specifications. 2. Entrapment Risk: Conduct physical inspections of the bed rail and mattress to identify and eliminate potential entrapment hazards. Refer to FDA guidelines for dimensional limits on spaces within, around, and between bed rails and	02310		

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02310	Continued From page 25 the mattress. 3. CPSC Check: Verify the specific portable bed rail model has not been recalled by the Consumer Product Safety Commission. 4. Manufacturer's Guidelines: Manufacturer's guidelines must be readily accessible. The MDH website, Assisted Living Resources & FAQs indicated licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance and use. In addition, licensees should refer to the Consumer Product Safety Commission (CSPC) for the most up-to-date information related to portable bed side rail recall information. To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint... Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30908	A. BUILDING: _____ B. WING _____	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOULDER CREEK	604 VILLAGE DRIVE MARSHALL, MN 56258

(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
02310	Continued From page 26 installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE The license took immediate action to mitigate the identified risk. Scope and level remains at I.	02310		

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Boulder Creek Assisted Living
604 Village Drive
Marshall, MN 56258
Lyon County
Parcel:

Phone:

License Info

License: HFID 30908

Risk:
License:
Expires on:
CFPM: Cathy E. Hutchins
CFPM #: 87429; Exp: 1/29/2026

Inspection Info

Report Number: F7990251009
Inspection Type: Full - Single
Date: 6/25/2025 Time: 10:41:47 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

NORTH AND SOUTH SERVING KITCHENS INSPECTED. WE DISCUSSED EMPLOYEE ILLNESS, NOROVIRUS PREVENTION, AND HANDWASHING. AN EMPLOYEE ILLNESS LOG WAS ONSITE.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Mankato District Office inspection report number F7990251009 from 6/25/2025

Benjamin D. Ische

Jan Mason
Manager

Ben Ische,
Public Health Sanitarian Supervisor
507-344-2710
ben.ische@state.mn.us

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Temperature Observations/Recordings

Establishment Info

Boulder Creek Assisted Living
Marshall
County/Group: Lyon County

Inspection Info

Report Number: F7990251009
Inspection Type: Full
Date: 6/25/2025
Time: 10:41:47 AM

Food Temperature: Product/Item/Unit: HOT HOLD PORK**; Temperature Process:** Hot-Holding
Location: Steam Table at 192 Degrees F.
Comment: NORTH KITCHEN
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: NORLAKE REACH IN COOLER**; Temperature Process:** Ambient Air
Location: Cooler at 39 Degrees F.
Comment: NORTH KITCHEN
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: NORLAKE REACH IN COOLER**; Temperature Process:** Ambient Air
Location: Cooler at 41 Degrees F.
Comment: SOUTH KITCHEN
Violation Issued?: No

Mankato District Office
Minnesota Department of Health
12 Civic Center Plaza, Suite 2105
Mankato, MN 56001

Sanitizer Observations/Recordings

Establishment Info

Boulder Creek Assisted Living
Marshall
County/Group: Lyon County

Inspection Info

Report Number: F7990251009
Inspection Type: Full
Date: 6/25/2025
Time: 10:41:47 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 166 Degrees F.
Comment: SOUTH KITCHEN
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 160 Degrees F.
Comment: NORTH KITCHEN
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 100 PPM
Comment: NORTH KITCHEN
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 100 PPM
Comment: SOUTH KITCHEN
Violation Issued?: No