Electronically Delivered

March 7, 2025

Licensee
New Creation Social Services LLC
14011 Juniper Circle Northwest
Andover, MN 55304

RE: Project Number(s) SL38378016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 31, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 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
	38378	A. BUILDING: _____ B. WING _____	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CREATION SOCIAL SERVICES LLC	14011 JUNIPER CIRCLE NORTHWEST ANDOVER, MN 55304

(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 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: SL38378016 On January 27, 2025 through January 31, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 3 residents; 3 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.	
0 130 SS=F	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility	0 130		

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0 130	Continued From page 1 license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater	0 130		

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0 130	Continued From page 2 and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or	0 130		

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0 130	Continued From page 3 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked	0 130		

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0 130	Continued From page 4 under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to meet the definition of an assisted living facility when the licensee had non-resident individuals (chief executive officer/unlicensed personnel (CEO/ULP)-A and two children) residing 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 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 January 27, 2025, at 2:19 p.m., CEO/ULP-A stated CEO/ULP-A, her 18-year-old daughter, and 5-year-old son, reside on the third level of the facility. There was not a separate entrance to the third level, there was not a separate kitchen, and the address used by CEO/ULP-A and her children was the same as the facility address. CEO/ULP-A stated she had not completed a variance or waiver request following their initial survey on November 1, 2022, through November 3, 2022.	0 130		

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0 130	Continued From page 5 Subd. 4a.Assisted living facility campus. "Assisted living facility campus" or "campus" means: (1) a single building having two or more addresses, located on the same property with a single property identification number. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 130		
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 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	0 480		

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0 480	Continued From page 6 clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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	0 480		

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0 480	Continued From page 7 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 January 27, 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		
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 make emergency and disaster training annually	0 680		

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0 680	Continued From page 8 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 have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, 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 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 the residents). The findings include: On January 27, 2025, at 12:42 p.m., chief executive officer / unlicensed personnel (CEO/ULP)-A provided licensee's Emergency Disaster Plan. The licensee's EPP plan lacked evidence of the following required content: - EPP reviewed and updated annually - hazard vulnerability assessment - EP testing requirements. On January 28, 2025, at 2:15 p.m., CEO/ULP-A stated they had made updates to the emergency	0 680		

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0 680	Continued From page 9 plan following their last survey, they were not aware that it was missing required information. The licensee's Emergency Preparedness policy dated March 23, 2023, indicated [the facility] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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 install and maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 790		

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0 790	Continued From page 10 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: On January 29, 2025, at 11:45 a.m., the surveyor toured the facility with owner/unlicensed personnel (O/ULP)-C. During the tour, the surveyor observed the following: 1. Portable fire extinguishers were located in the basement and main floor laundry room. 2. Tags or labels were not attached to the portable fire extinguishers showing annual maintenance had been performed by certified service personnel. The bottom of the fire extinguishers were date stamped 2021. 3. Four monthly fire extinguisher inspections were recorded in 2024. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. 4. The fire extinguisher in the basement was stored on a wall shelf. The fire extinguisher in the laundry room was stored on a sink counter. Fire extinguishers must be properly installed to prevent them from being moved or damaged. Fire extinguishers need to be mounted at least 4 inches above the floor and installed so the top of the extinguisher is not more than 60 inches above the floor. 5. A sign was posted on a kitchen cabinet indicating a fire extinguisher was stored in this location. A fire extinguisher was not mounted inside the cabinet. Fire extinguishers must be	0 790		

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0 790	Continued From page 11 installed in designated locations to prevent confusion or delay in accessing a fire extinguisher during an emergency. During the tour interview, O/ULP-C verified the above listed observations. During an interview on January 29, 2025, at 12:30 p.m., chief executive officer/unlicensed personnel (CEO/ULP)-A stated new fire extinguishers had already been purchased and would be installed right away. The new fire extinguishers and a receipt dated January 29, 2025, were provided to the surveyor for review. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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	0 810		

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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
0 810	Continued From page 12 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 safety and evacuation plan with required content, and provide required training and 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: On January 29, 2025, chief executive officer/unlicensed personnel (CEO/ULP)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP failed to accurately identify the location	0 810		

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	38378	A. BUILDING: _____ B. WING _____	01/31/2025

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0 810	Continued From page 13 and number of resident sleeping rooms and the locations of installed portable fire extinguishers. On January 29, 2025, at 11:45 a.m., the surveyor toured the facility with owner/unlicensed personnel (O/ULP)-C. During the tour, the surveyor observed the following: 1. The FSEP floor plan labeled fire extinguishers on the upper floor and in the kitchen. Portable fire extinguishers were not installed in these locations. The plan of emergency procedures directed the building occupants to fire extinguishers under the kitchen sink and in the downstairs employee office. Portable fire extinguishers were not installed in these locations. Fire extinguisher locations must be accurately identified on the FSEP floor plan and in the emergency procedures to prevent confusion or delay in accessing a fire extinguisher during an emergency. 2. O-ULP-C verbally identified resident sleeping rooms. The surveyor observed room identifiers were not posted at the resident sleeping room doors. Sleeping room identifiers are required to be posted on or at the resident sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. The posted sleeping room identifiers must correspond with the sleeping room labels on the FSEP floor plan. 3. Record review of the available documentation indicated the licensee failed to identify each resident sleeping room with a unique identifier on the fire safety and evacuation floor plan. There were three sleeping rooms labeled as bedroom 1, two sleeping rooms labeled as bedroom 2, and two sleeping rooms labeled as bedroom 3. The use of the same sleeping room identifiers would be confusing during the event of an emergency. During an interview on January 29, 2025, at 12:30 p.m., CEO/ULP-A verified the FSEP required	0 810		

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0 810	Continued From page 14 revision. The licensee failed to develop and maintain the FSEP. 4. Record review of the available documentation indicated the licensee had labeled the door leading into the attached garage as an emergency exit on the floor plan. The plan of emergency procedures directed the building occupants to evacuate through the garage door. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room. 5. The FSEP included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. 6. The FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation during a fire or similar emergency including individualized unique needs of residents. 7. The FSEP plan for relocation was not accurate. The building occupants were directed to meet at the fence across the parking lot. On January 29, 2025, at 11:45 a.m., the surveyor toured the facility with owner/unlicensed personnel (O/ULP)-C. During the tour, the surveyor observed there was not a fence across the parking lot. During an interview on January 29, 2025, at 12:30 p.m., CEO/ULP-A verified the FSEP required revision. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year evident by training documentation that did not support this had been completed. Four fire safety meetings	0 810		

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0 810	Continued From page 15 were recorded in 2024. These meeting records did not indicate training on the FSEP had been conducted. Additionally, the names of the employees who attended were not recorded. During an interview on January 29, 2025, at 12:30 p.m., CEO/ULP-A stated employees were training on the FSEP and verified the trainings were not properly documented. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of completed fire drill reports lacking the required frequency. Four evacuation fire drills were completed in 2024. Morning drills were completed in March and November. Afternoon drills were completed in June and September. No night shift drills were conducted. During an interview on January 29, 2025, at 12:30 p.m., CEO/ULP-A verified the evacuation fire drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01610 SS=D	144G.70 Subd. 2 (a-b) 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	01610		

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01610	Continued From page 16 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to a conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs for one of one resident (R1) on or before the admission date and 14-days after the initiation of 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 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: R1 was admitted to the facility and began receiving services on August 4, 2024. R1's service plan dated September 6, 2024, indicated assistance with meals, personal hygiene, dressing, transferring, toileting, transportation, laundry, housekeeping, shopping, behavior management and medication set-up for self-administration of medications.	01610		

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01610	Continued From page 17 R1's record lacked a pre-admission assessment. R1's record indicated a 14-day assessment was completed on September 21, 2024, 42 days after the initial assessment. On January 28, 2025, at 12:10 p.m., chief executive officer / unlicensed personnel (CEO/ULP)-A stated a pre-admission assessment was not completed because CEO/ULP-A made the decision to allow R1 to reside at their assisted living for a respite stay. CEO/ULP-A stated resident did receive services since the date of admission. The licensee's Assessment and Reassessment Policy dated A March 23, 2023, indicated the initial registered nurse (RN) assessment shall be completed prior to the date on which the prospective resident executes a contract or on the date on which the prospective resident moves in, whichever is earlier. The RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
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	01620		

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01620	Continued From page 18 resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse used the uniform assessment tool for ongoing assessments and monitoring 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) 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: During the entrance conference on January 27,	01620		

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01620	Continued From page 19 2025, at 11:03 a.m., chief executive officer / unlicensed personnel (CEO/ULP)-A stated the licensee completed intake, 90-day, and change in condition assessments. R1 was admitted and began receiving services on August 4, 2024. R1's record included an initial assessment dated August 10, 2024, and a 90-day assessment dated January 18, 2025. R1's initial and 90-day assessments lacked required elements of the uniform assessment tool: - personal lifestyle preferences, including sleep schedule and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life, spiritual and cultural preferences and advance health care directives and end-of-life preferences - activities of daily living, including toileting, dressing, grooming, bathing, personal hygiene, mobility, dental status, oral care, and dentures - instrumental activities of daily living, including ability to self-manage medications, housework, laundry and transportation - physical health status, including a review of relevant health history and current health conditions including medical and nursing diagnoses, allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities and life threatening, infectious conditions - review of medications according to Minnesota Statutes section 144G.71, subdivision 2 - a review of medical, dental and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility	01620		

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01620	Continued From page 20 - review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months - emotional and mental health conditions, including review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders, effective medication treatment and non-medication interventions - cognition, including a review of any neurocognitive evaluations and diagnoses - communication and sensory capabilities, including hearing, vision, speech, assistive communication and sensory devices including hearing aids, and the ability to understand and be understood -nutritional and hydration status and preferences - list of treatments, including type, frequency, and level of assistance needed - nursing needs - risk indicators including risk for falls including history of falls, emergency evaluation ability, risk for dehydration, including history of urinary tract infections and current fluid intake pattern, risk for emotional or psychological distress due to personal losses, unsuccessful prior placements, elopement risk including history or previous elopements, smoking, including the ability to smoke without causing burns or injury to the resident or others or damage property and alcohol and drug use, including the resident's alcohol or drug use not prescribed by a physician - who has decision making authority for the resident including the presence of any advance health care directive or other legal document that establishes a substitute decision maker and the scope of decision-making authority of a substitute decision maker - the need for follow-up referrals for additional medical or cognitive care by health professionals	01620		

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01620	Continued From page 21 On January 31, 2025, at 12:20 p.m., clinical nurse supervisor (CNS)-D stated she was not aware a uniform assessment tool needed to be used. CNS-D stated she used a three-page assessment form from John Hopkins, or wrote a nurses note in the resident's medical record that summarized the nursing assessment. The Minnesota Administrative Rule 4659.0150 dated August 11, 2021, indicated each facility must develop a uniform assessment tool to include all the required elements. The licensee's Comprehensive Nursing Assessment policy dated March 23, 2023, indicated the registered nurse (RN) will conduct a comprehensive assessment utilizing a uniform assessment tool. 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 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	01640		

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01640	Continued From page 22 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 written service plan was revised to reflect the current services provided and to ensure the service plan included a signature or other authentication by the resident or resident's designated representative and the licensee to document agreement on the services to be provided for 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 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: R1 was admitted to the facility and began receiving services on August 4, 2024. R1's service plan dated September 6, 2024, indicated assistance with meals, personal	01640		

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01640	Continued From page 23 hygiene, dressing, transferring, toileting, transportation, laundry, housekeeping, shopping, behavior management and medication set-up for self-administration of medications. R1's service plan lacked revision to reflect the current services R1 was receiving. R1's Medication Administration Record dated January 2025, indicated R1 received the following medications administered by staff: -acetaminophen (for pain) 500 milligrams (mg) three times daily -alendronate sodium (for osteoporosis) 70 mg once weekly -aripiprazole (anti-psychotic) 5 mg daily -aspirin (for heart health maintenance) 81mg daily -calcium (supplement) 600 mg twice daily -docusate sodium (for constipation) 100 mg twice daily -fish oil (supplement) 1200 mg daily -gabapentin (for pain) 300 mg three times daily -hydrochlorothiazide (for hypertension) 25 mg daily -losartan potassium (for hypertension) 100 mg daily -nifedipine ER (for hypertension or angina) 90 mg daily -polyethylene glycol 3350 (for constipation)17 grams three times daily -rosuvastatin calcium (for high cholesterol) 40 mg daily -vitamin D3 (supplement) 50 mg daily. On January 31, 2025, at 1:30 p.m. licensed assisted living director (LALD)-B and chief executive officer / unlicensed personnel (CEO/ULP)-A stated they were aware service plans need to be updated with any service change and signed by the resident or resident	01640		

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01640	Continued From page 24 representative and they were unsure why it hadn't been completed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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 medications.	01700		

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01700	Continued From page 25 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an assessment to determine what medication management services would be provided and how the medication services would be provided 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) 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: R1 was admitted to the facility and began receiving services on August 4, 2024. R1's service plan dated September 6, 2024, indicated assistance with meals, personal hygiene, dressing, transferring, toileting, transportation, laundry, housekeeping, shopping, behavior management and medication set-up for self-administration of medications. R1's record lacked a medication assessment. On January 31, 2025, at 12:24 p.m., clinical nurse supervisor (CNS)-D stated she had no knowledge of the medication assessment or individualized medication management record requirements and had not been doing them for any resident. The licensee's Assessment of Medications policy dated March 23, 2023, indicated prior to providing	01700		

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01700	Continued From page 26 medication management services, [the facility] will provide an assessment by a registered nurse (RN) to determine what medication management services will be provided and how they will be implemented. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The 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	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38378	A. BUILDING: _____ B. WING _____	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CREATION SOCIAL SERVICES LLC	14011 JUNIPER CIRCLE NORTHWEST ANDOVER, MN 55304

(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
01730	Continued From page 27 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 licensee failed to develop and maintain a current individualized medication management record to include all 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) 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: R1 was admitted to the facility and began receiving services on August 4, 2024. R1's service plan dated September 6, 2024, indicated assistance with meals, personal	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38378	A. BUILDING: _____ B. WING _____	01/31/2025

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01730	Continued From page 28 hygiene, dressing, transferring, toileting, transportation, laundry, housekeeping, shopping, behavior management and medication set-up for self-administration of medications. R1's record lacked a medication management record. R1's Medication Administration Record dated January 2025, indicated R1 received the following medications: -acetaminophen (for pain) 500 milligrams (mg) three times daily -alendronate sodium (for osteoporosis) 70 mg once weekly -aripiprazole (anti-psychotic) 5 mg daily -aspirin (for heart health maintenance) 81mg daily -calcium (supplement) 600 mg twice daily -docusate sodium (for constipation) 100 mg twice daily -fish oil (supplement) 1200 mg daily -gabapentin (for pain) 300 mg three times daily -hydrochlorothiazide (for hypertension) 25 mg daily -losartan potassium (for hypertension) 100 mg daily -nifedipine ER (for hypertension or angina) 90 mg daily -polyethylene glycol 3350 (for constipation)17 grams three times daily -rosuvastatin calcium (for high cholesterol) 40 mg daily -vitamin D3 (supplement) 50 mg daily On January 31, 2025, at 12:24 p.m., clinical nurse supervisor (CNS)-D stated she had no knowledge of the medication assessment or individualized medication management record requirements and had not been doing them for any resident.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NEW CREATION SOCIAL SERVICES LLC	14011 JUNIPER CIRCLE NORTHWEST ANDOVER, MN 55304

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01730	Continued From page 29 The licensee's Service Plan for Medication Management dated March 23, 2023, indicated [the facility] will prepare and document a medication management plan as part of the service plan for each resident receiving medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to discard expired medication for one of three residents (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 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:	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38378	A. BUILDING: _____ B. WING _____	01/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CREATION SOCIAL SERVICES LLC	14011 JUNIPER CIRCLE NORTHWEST ANDOVER, MN 55304

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01890	Continued From page 30 During the entrance conference on January 27, 2025, at 10:50 a.m., chief executive officer / unlicensed personnel (CEO/ULP)-A stated the licensee provided medication management services to residents at the facility. On January 28, 2025, at 10:12 a.m., the surveyor observed the locked medication cabinet with CEO/ULP-A and observed the following expired medication for R3: - Quetiapine 25 milligram (mg) with an expiration date of October 1, 2024. On January 28, 2025, at 10:18 a.m., CEO/ULP-A stated ULP's and clinical nurse supervisor (CNS)-D check expiration dates on the medications on a regular basis and place them in the destruction bin as needed. She stated medication audits were completed by CNS-D on a routine basis. On January 31, 2025, at 12:18 a.m., CNS-D stated the ULP's have been trained to check for expired medications at the end of every month and this one must have been missed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38378	A. BUILDING: _____ B. WING _____	01/31/2025

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NEW CREATION SOCIAL SERVICES LLC	14011 JUNIPER CIRCLE NORTHWEST ANDOVER, MN 55304

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01910	Continued From page 31 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 all required content for disposition of medications including expired, discontinued, wasted, and discharged resident medications. 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). Based on interview and record review, the licensee failed to document all required content for disposition of medications including expired, discontinued, wasted, and discharged resident medications.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 32 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 January 27, 2025, at 10:50 a.m., chief executive officer / unlicensed personnel (CEO/ULP)-A stated the licensee provided medication management services to residents at the facility. On January 27, 2025, at 10:18 a.m., CEO/ULP-A stated that CEO/ULP-A, owner / unlicensed personnel (O/ULP)-C, or clinical nurse supervisor (CNS)-D discard unused medications as needed. On January 28, 2025, at 3:15 p.m., licensed assisted living director (LALD)-B stated they have not documented disposition of any medications, and they were not aware of the requirement. On January 31, 2025, at 12:14 p.m., CNS-D stated she knew they needed a place to store medications that needed to be destroyed, but she was not aware of the requirements to document each medication in the resident's medical record. The licensee's Disposition and Disposal of Medications policy dated March 23, 2023, indicated, upon disposition, [the facility] will document the following information in the clinical record a. Name, strength and prescription number of	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 33 medication, as applicable b. Quantity c. Method of disposition or to whom the medications were given d. Date of disposition e. Name(s)/signature(s) of staff or other individuals involved in disposition f. If applicable, to whom the medications were given No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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03090	Continued From page 34 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 the residents). The findings include: On January 27, 2025, at 11:15 a.m., the surveyor observed the lack of an electronic monitoring notice to visitors. On January 27, 2025, at 11:28 a.m., chief executive officer / unlicensed personnel (CEO/ULP)-A stated they did not have the notice posted and they were not aware of the requirement. The licensee's Electronic Monitoring policy dated March 23, 2023, indicated [the facility] will post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *01/27/25*
Time: 11:32:40
Report: 1029251022

Food and Beverage Establishment Inspection Report

Location:

New Creation Social Services
14011 Juniper Circle NW
Andover, MN55304
Anoka County, 02

Establishment Info:

ID #: 0040909
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/22

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG. WENT TO MDH SITE DURING INSPECTION AND DOWNLOADED ILLNESS LOG. EMPLOYEE ILLNESS LOGGING AND EXCLUSION COVERED WITH OPERATOR.

Comply By: 01/27/25

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

UNPASTEURIZED SHELL EGGS NOT ADEQUATELY SEPARATED FROM READY TO EAT ITEMS. OPERATOR INSTRUCTED TO HOLD IN A DIFFERENT FASHION TO ELIMINATE THE POSSIBILITY OF CROSS CONTAMINATION. INFORMATION ON SEPARATION AND STRATIFICATION PROVIDED W/ REPORT.

Comply By: 01/29/25

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

DATE MARKS ABSENT FROM OPENED PACKAGES OF DELI MEAT AND HOT DOGS. DELI MEAT DATE MARKED AND HOT DOGS DISCARDED (OPEN DATE UNKNOWN). DATE MARKING PRACTICES COVERED WITH OPERATOR. DATE MARKING INFO PROVIDED WITH REPORT.

Comply By: 01/29/25

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.

NO QUAT STRIPS. OPERATOR INSTRUCTED TO MAINTAIN TEST STRIP SUPPLY FOR SANITIZER OF CHOICE. 3 TEST STRIPS PROVIDED TO OPERATOR AND PICTURE TAKEN OF COLOR [] CHART TO ALLOW OPERATOR TO TEST UNTIL ESTABLISHMENT SUPPLY IS OBTAINED THE NEXT DAY.

Comply By: 01/27/25

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

DAMP WIPING CLOTH NOT IN SANITIZER SOLUTION. OPERATOR INSTRUCTED TO KEEP WIPING CLOTHS IN SANITIZER SOLUTION WHEN NOT IN USE. QUAT BUCKET MIXED WITH OPERATOR DURING INSPECTION.

Comply By: 01/27/25

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

GAP AT COUNTER WALL JUNCTURE BEHIND SINK AND FLOOR CABINETRY UNDER SINK. OPERATOR INSTRUCTED TO SEAL AND TO REPAIR OR REPLACE IF UNSANITARY CONDITIONS ARISE OR IF PEST HARBORAGE CONDITIONS OCCUR DUE TO FAILING FINISHES AND MATERIALS.

Comply By: 08/29/25

Surface and Equipment Sanitizers

QUATERNARY AMMONIUM: = 200 PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

HOT WATER: = at >150 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: *01/27/25*
Time: 11:32:40
Report: 1029251022
New Creation Social Services

Food and Beverage Establishment Inspection Report

Process/Item: COLD HOLDING/DELI MEAT
Temperature: 42 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: COLD HOLDING/MILK
Temperature: 38 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

TOPICS COVERED:
- HIGH HEAT AND CHEMICAL SANITIZING
- TEMPERATURE CONTROL
- PROTECTION FROM CONTAMINATION
- EMPLOYEE ILLNESS LOGGING
- ILLNESS EXCLUSION REQUIREMENTS
- REPORTING REQUIREMENTS
- COMMON FOODBORNE ILLNESS PATHOGENS
- VOMIT/FECAL MATTER CLEANUP PROCEDURE
- DATE MARKING AND LISTERIA MONOCYTOGENES
- HIGHLY SUSCEPTIBLE POPULATION
- EMPLOYEE HYGIENE AND HANDWASHING
- GLOVE/UTENSIL USE AND BARE-HAND-CONTACT
- PEST CONTROL

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 1029251022 of 01/27/25.

Certified Food Protection Manager: TEMEKA R. THEDFORD

Certification Number: 108855 Expires: 11/24/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
TEMEKA THEDFORD
LALD

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

Food Establishment Inspection Report

Report #: 1029251022

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

No. of RF/PHI Categories Out	3	**Date**	01/27/25
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:32:40
Legal Authority MN Rules Chapter 4626		**Time Out**	

New Creation Social Services	**Address** 14011 Juniper Circle NW	**City/State** Andover, MN	**Zip Code** 55304	**Telephone**
License/Permit # 0040909	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 01/29/25

Inspector (Signature) Trevor McCliment