Electronically Delivered

December 20, 2022

Administrator
Creekside Cottage Assisted Living
1190 117th Avenue Northwest
Coon Rapids, MN 55448

RE: Project Number(s) SL24666015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 2, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24666	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE COTTAGE ASSISTED LIVING	1190 117TH AVENUE NW COON RAPIDS, MN 55448

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#24666015-0 On October 31, 2022, through November 2, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were ten (10) residents, receiving services under the provider's Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250		

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

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0 250	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure by attesting the managerial officials who were in charge of the day-to-day operations developed and implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 31, 2022, at 9:45 a.m., licensed assisted living director (LALD)-C stated licensee was familiar with the Assisted Living laws and regulations.	0 250		

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0 250	Continued From page 3 The licensee's "Application for Assisted Living License," section titled, "Official Verification of Owner or Authorized Agent" (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17; - I have read and fully understand Minn. Stat. sect. 144G.80 144G.81 and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable; - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G; - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659; - Reporting of Maltreatment of Vulnerable Adults; - Electronic Monitoring in Certain Facilities; - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or	0 250		

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0 250	Continued From page 4	0 250		

misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices;

- I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license;

- I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract;

- I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in

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0 250	Continued From page 5 writing, of any changes to this information as required; and - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 (proposed and not final) in place upon licensure and to keep them current as applicable." Page five was electronically signed by owner (O)-E on May 28, 2021. As a result of this survey, the following orders were issued: - 144G.40 Subd. 2. Uniform checklist disclosure of services; - 144G.41 Subdivision 1. (5-10) Minimum requirements; - 144G.41 Subdivision 1. (11-12) Minimum requirements; - 144G.41 Subdivision 1. (13) (i) (B) Minimum requirements; - 144G.41 Subd. 1. (13) (i) (A & C) Minimum requirements; - 144G.41 Subdivision 1. (13) (ii-vii) Minimum requirements; - 144G.41 Subd. 7. Resident grievances; reporting maltreatment; - 144G.42 Subd. 6. (b) Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan; - 144G.42 Subd. 7 Posting information for reporting suspected crime and maltreatment; - 144G.42 Subd. 9. Tuberculosis prevention and control; - 144G.42 Subd. 10. Disaster planning and emergency preparedness plan; - 144G.45 Subd. 2 (a) (4) Fire protection and physical environment; - 144G.45 Subd. 2 (b-f) Fire protection and	0 250		

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0 250	Continued From page 6 physical environment; - 144G.50 Subdivision 1. Contract required; - 144G.60 Subdivision 1. Background studies required; - 144G.62 Subd. 4. Supervision of staff providing delegated nursing or therapy tasks; - 144g.64 (a) (3) Training in dementia care required; - 144G.70 Subd. 2. (c) Initial reviews, assessments, and monitoring; - 144G.70 Subd. 4. (a-e) Service plan, implementation, and revisions to service plan; - 144G.71 Subd. 13. Prescriptions; - 144G.71 Subd. 20. Prescription drugs; - 144G.72 Subd. 3. Individualized treatment or therapy management plan; - 144G.72 Subd. 4. Administration of treatments and therapy; - 144G.72 Subd. 5. Documentation of administration of treatments and therapies; - 144G.72 Subd. 6. Treatment and therapy orders; - 144G.81 Subdivision 1. Fire protection and physical environment; - 144G.82 Subd. 3. Policies; - 144G.83 Subd. 3. Supervising staff training; - 144G.90 Subdivision 1. Assisted living bill of rights; notification to resident; and - 144G.91 Subd. 4. Appropriate care and services, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		

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0 430	Continued From page 7	0 430		
0 430 SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services with the required content for one of one resident. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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	0 430		

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0 430	Continued From page 8 portion or all of the residents). The findings include: R1 was admitted to licensee October 31, 2021. R1's diagnosis was congestive heart failure. R1's Health Management Care Plan dated September 19, 2022, indicated R1 was receiving the following services: blood glucose monitoring, foot checks, shower, oxygen monitoring, monitor cardiovascular (blood pressure and heart rate) within normal parameters, skin integrity, and prevention of falls. R1's record lacked a uniform disclosure of assisted living services and amenities (UDALSA) checklist to include: - a disclosure of the categories of assisted living licenses available and the category of license held by the facility; and - a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide. On October 31, 2022, at 11:40 a.m., licensed assisted living director (LALD)-C stated R1 and all other residents who received services under their assisted living facility with dementia care license had not received a written checklist listing all services provided under the facility's assisted living license, and the services not provided under the facility's license. The licensee Uniform Checklist policy dated August 1, 2021, indicated uniform checklist of services must be provided to all prospective	0 430		

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0 430	Continued From page 9 residents before a contract is executed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 460		

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0 460	Continued From page 10 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 October 31, 2022, at 10:32 a.m., licensed assisted living director (LALD)-C, and registered nurse (RN)-A verified the licensee lacked a system for residents to request staff assistance when needed 24 hours a day. LALD-C stated residents were alert and oriented and can shout out or walk out of their rooms to ask for assistance. LALD-C also stated staff conducted two-hour checks on residents. On November 1, 2022, at 7:30 a.m., during medication administration in R1's, the surveyor observed R1 did not have a system in place to call for assistance. R1 stated the only way to call for assistance was to shout out to staff and if they heard you they will respond. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of	0 470		

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0 470	Continued From page 11 staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the 24-hour staffing schedule was posted in a central location for residents, staff and visitors to review as required. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 470		

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	24666	A. BUILDING: _____ B. WING _____	11/02/2022

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0 470	Continued From page 12 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 October 31, 2022, at 10:50 a.m., during a facility tour, the surveyor observed the licensee lacked the posting of a daily staffing schedule developed by the clinical nurse supervisor to: - direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location. On October 31, 2022, at 11:10 a.m., licensed assisted living director (LALD)-C verified no staffing schedule was posted in a central location. LALD-C stated all schedules are located online and all staff have access to the schedules. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the	0 480		

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0 480	Continued From page 13 recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated October 31, 2022. No further information provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 485	Continued From page 14	0 485		
0 485 SS=F	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a menu was prepared a week in advance and provided to the residents. This had the potential to affect all ten (10) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 485		

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0 485	Continued From page 15 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 October 31, 2022, at approximately 10:30 a.m., during entrance conference, licensed assisted living director (LALD)-C stated the menu is developed and posted weekly. In addition, LALD-C stated the menu for the week was posted in the common area of home. On October 31, 2022, at 11:00 a.m., the surveyor observed a posted menu dated between October 30, 2022, and November 5, 2022, for one week. The posted menu lacked a week in advance as required. On October 31, 2022, LALD-C verified the posted menu was only for a week, and stated the licensee will update the menu to reflect the requirements. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying	0 490		

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0 490	Continued From page 16 information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities that are based upon individual/group interests, and physical, mental, and psychosocial needs for all the residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 31, 2022, at 9:50 a.m., during the entrance conference, licensed assisted living	0 490		

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0 490	Continued From page 17 director (LALD)-C stated the licensee provided a daily program of social and recreational activities. On October 31, 2022, at 10:20 a.m., a posted activities schedule for October 30, 2022, through November 5, 2022, indicated activities are scheduled Monday through Friday in the hours between approximately 2:00 p.m. and 4:30 p.m. During observations on October 31, 2022, and November 1,2022, in the morning hours between 10:00 a.m. and 2:00 p.m., the surveyor observed no activities were planned or offered by the licensee for the residents. Six of the ten residents sat in front of a television, some sleeping in their wheelchairs while other residents remained in their rooms and still others paced in the hallways. During an interview on November 1, 2022, at 10:40 a.m., registered nurse (RN)-A stated the licensee has activities for the residents, except for this day the residents had a memorial service for a resident who passed away. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional	0 550		

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0 550	Continued From page 18 Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities. This had the potential to affect all ten (10) residents receiving assisted living 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) 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 October 31, 2022, at 11:50 a.m., during the facility tour, the surveyor did not observe a posting in a common area of the grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of posting in the common area of contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.	0 550		

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0 550	Continued From page 19 During an interview on October 31, 2022, at 12:20 p.m., licensed assisted living director (LALD)-C verified the required information regarding the grievance process and the ombudsman contact information were not posted in the common areas of the facility. In addition, LALD-C stated the information is provided to residents and their families during admission. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed and included statements of the specific measures to be taken to minimize the risk of abuse for three of three residents (R1, R2, R4).	0 630		

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0 630	Continued From page 20 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on October 31, 2021, with diagnoses including congestive heart failure, hypertension, and muscle weakness. R1's record lacked an IAPP and statements of the specific measures to be taken to minimize the risk of abuse to R1 and other vulnerable adults. R2 R2 admitted to the licensee on February 3, 2022, with a diagnosis of type II diabetes. R2's IAPP updated July 16, 2022, indicated R2 had one area of potential vulnerability to include: financial exploitation. R2's IAPP lacked individualized review or assessment of R2's susceptibility to abuse by another individual, including other vulnerable adults, and statements of the specific measures to be taken to minimize the risk of abuse to R2 and other vulnerable adults. R4 R4 admitted to the licensee on February 7, 2020, with diagnosis of paranoid schizophrenia. R4's IAPP updated July 16, 2022, indicated R4 had one area of potential vulnerability to include:	0 630		

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0 630	Continued From page 21 financial exploitation. R4's IAPP lacked individualized review or assessment of R4's susceptibility to abuse by another individual, including other vulnerable adults, and statements of the specific measures to be taken to minimize the risk of abuse to R4 and other vulnerable adults. On November 1, 2022, at 10:20 a.m., licensed assisted living director (LALD)-C confirmed R1's record lacked an IAPP. LALD-C stated R2 and R4's IAPPs required an update to reflect the correct assessment for the residents' vulnerability. In addition, LALD-C stated all the licensee's residents' IAPPs will be lacking the same information as the licensee uses the same generic form to assess for vulnerability. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language.	0 640		

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0 640	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all ten (10) residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the clients). The findings include: On October 31, 2022, at 10:50 a.m., during a facility tour an observation was made of the facility's common areas and the surveyor noted the licensee lacked the required posting of the emergency number and information related to reporting suspected maltreatment to MAARC. During an interview on October 31, 2022, at 12:29 p.m., licensed assisted living director (LALD)-C verified the required information was not posted in the common areas of the facility, and stated the licensee provided to the residents and their families the information at admission. No further information was provided.	0 640		

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0 640	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 660		

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0 660	Continued From page 24 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally) The findings include: On October 31, 2022, at approximately 11:00 a.m., registered nurse (RN)-A provided the facility TB risk assessment. The TB risk assessment dated September 6, 2022, indicated the licensee was low risk. ULP-D started employment with licensee April 21, 2020, under the comprehensive license and started providing assisted living services August 1, 2021. ULP-D's record included unsigned QuantiFERON TB Gold plus results date stamped November 15, 2020, indicating ULP-D was negative for TB. ULP-D's employee record lacked evidence of a TB history and symptom screening On November 2, 2022, at approximately 11:05 a.m., licensed assisted living director (LALD)-C verified ULP-D's employee record did not include a completed TB history and symptom screening. Additionally, RN-A stated the facility policy indicated for this to be completed upon hire and indicated this documentation should be kept in the employee file. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an	0 660		

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0 660	Continued From page 25 employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." An undated facility policy entitled Tuberculosis Screening indicated each employee having direct contact with clients must have documentation of baseline health screening prior to providing care to clients. This includes, at a minimum, TB skin testing via the Mantoux method. This testing includes the pre-placement evaluation, administration and interpretation of TB Mantoux skin tests and periodic evaluation based on agency risk assessment or a negative IGRA (blood test). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following 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;	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24666	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE COTTAGE ASSISTED LIVING	1190 117TH AVENUE NW COON RAPIDS, MN 55448

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 680	Continued From page 26 (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EP plan lacked the following:	0 680		

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0 680	Continued From page 27 - Develop and Maintain EP Program; - Maintain and Annual EP Updates; - EP Program Patient Population; - Process for EP Collaboration; - Development of EP Policies and Procedures; - Subsistence Needs for Staff and Patients; - Procedures for Tracking of Staff and Patients; - Policies and Procedures for Sheltering; - Policies and Procedures for Medical Documents; - Policies and Procedures for Volunteers; - Arrangement with Other Facilities; - Primary/Alternate Means for Communication; - Methods for Sharing Information; - Sharing Information on Occupancy/Needs; - LTC Family Notifications; - Emergency Prep Training and Testing; - Emergency Prep Training Program; - Emergency Prep Testing Requirements; - LTC Emergency Power (Typically ENGINEERING); and - Integrated Health Systems On November 1, 2022, at 1:35 p.m., licensed assisted living director (LALD)-C acknowledged the EP plan was not complete and missing required information. Additionally, LALD-C stated the licensee will update the EP to reflect the requirement. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated, "[licensee] 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 additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 680		

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0 680	Continued From page 28 (21) days	0 680		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, and staff. 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: On November 1, 2022, approximately from 1:30 p.m. to 2:30 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-C. During the tour, survey staff observed and the LALD-C confirmed the following:	0 800		

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0 800	Continued From page 29 1) The exit gate for the courtyard had hardware that was not easily operable and therefore, limiting the means of egress to the public way from the dining door inside of the building with a sign to exit and evacuate into the courtyard. The LALD-C agreed and explained that the hardware needed to be repaired. 2) In resident bedroom unit 6, the floor was sticky, and the room had a strong odor. The LALD-C agreed that the floor needed to be cleaned. 3) Chemicals were stored under vanities and kitchen sink accessible to residents and posed concerns of misuse. 4) The ceiling of the furnace closet had openings around the ventilation duct and piping that needed to be fire-caulked. On November 1, 2022, at approximately 3:00 p.m., at the interview, LALD-C acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810		

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0 810	Continued From page 30 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, the required training on the fire safety and evacuation plan, and the minimum number of evacuation drills. This has the potential to directly affect the safety of occupied residents receiving care, 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	0 810		

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CREEKSIDE COTTAGE ASSISTED LIVING	1190 117TH AVENUE NW COON RAPIDS, MN 55448

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0 810	Continued From page 31 or has the potential to affect a large portion or all of the residents). The findings include: On November 1, 2022, at approximately 2:30 p.m., survey staff received the facility's fire safety and evacuation documentation and related documentation for review. Document review and interview with the licensed assisted living facility (LALD)-C at approximately 2:45 p.m. indicated the following: FIRE SAFETY AND EVACUATION PLAN 1) The floor plan layout incorrectly showed the attached one-car garage as an exit. 2)The plan documentation lacked fire protection procedures for residents that can self-assist during a fire or emergency. 3) The plan documentation did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. Unique situations that must be considered during an evacuation could be residents who have mobility limitations, cognitive impairment, deaf or blind, or any residents needing assistance including movement and evacuation that must be addressed in the fire safety and evacuation plan. DRILLS No fire and evacuation drill records were available for review. This was evident when the LALD-C stated that they do not have drill records. Survey staff explained that the minimum required number of evacuation drills is twice per year per shift, with at least one evacuation drill every other month for a total minimum of six drills in a year. They will need to carry out the drills as required and	0 810		

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0 810	Continued From page 32 maintain records to show compliance with the requirement. TRAINING 1) The licensee failed to provide employee training on the fire safety and evacuation plan upon hire and twice per year thereafter. The LALD-C provided the emergency preparedness training record for one employee without any noted training specific to fire safety and emergency documentation. 2) No resident training records were provided for review. The licensee did not provide annual training to residents who can assist in their evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation. Survey staff asked and the LALD-C stated that two residents are capable of self-assist during a fire or emergency. On November 1, 2022, at approximately 3:00 p.m., at the interview, LALD-C acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing;	0 900		

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0 900	Continued From page 33 (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written assisted living contract with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 900		

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0 900	Continued From page 34 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee converted to an Assisted Living with dementia care license on August 1, 2021. R1 was admitted to the licensee on October 31, 2021. R1's Health Management Care Plan dated September 19, 2022, indicated R1 was receiving the following services: blood glucose monitoring, foot checks, shower, oxygen monitoring, monitor cardiovascular (blood pressure and heart rate) within normal parameters skin integrity and prevention of falls. R1's record lacked a contract signed by licensee and R1 or R1's representative to include the required content with the residents prior to providing housing or assisted living services. On November 1, 2022, at 1:01 p.m., licensed assisted living director (LALD)-C stated none of the licensee's residents had executed a contract with the licensee. Additionally, LALD-C stated licensee was aware and was working to sign the contracts with all the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		

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01290	Continued From page 35	01290		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to 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 an employee 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 affiliated to licensee's HFID for two of two employees (unlicensed personnel (ULP)-B, ULP-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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-B On November 1, 2022, at 8:40 a.m., the surveyor	01290		

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01290	Continued From page 36 observed ULP-B prepare and serve breakfast for the licensee's residents in the dining room. ULP-B started employment with the licensee on May 27, 2020, under the comprehensive license, and started providing assisted living services on August 1, 2021. ULP-B's employee record included a Background Study Clearance dated August 5, 2022, which was not affiliated with the licensee. ULP-D On November 1, 2022, at 7:45 a.m., the surveyor observed ULP-D administer morning medications and check blood glucose for R1. ULP-D started employment with licensee on April 21, 2022. ULP-D's employee record included completed background study clearance dated August 5, 2022, which was not affiliated with the licensee. On November 1, 2022, at approximately 12:20 p.m., the NetStudy 2.0 website indicated ULP-B and ULP-D had not been affiliated to the provider's license. On November 1, 2022, at 12:30 p.m., licensed assisted living director (LALD)-C verified ULP-B and ULP-D were not affiliated to licensee. LALD-C also stated the licensee was aware of the lack of affiliation for all of the licensee's employees. In addition, LALD-C stated the licensee was working to affiliate all the employees. No further information was provided.	01290		

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01290	Continued From page 37 TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN-A) conducted supervision of unlicensed staff as required for one of one unlicensed personnel (ULP-B) with record reviewed. This practice resulted in a level two violation (a	01440		

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01440	Continued From page 38	01440		

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:

ULP-B started employment with licensee on May 27, 2020, under the comprehensive license, and started providing assisted living services on August 1, 2021.

On November 1, 2022, at 8:40 a.m., the surveyor observed ULP-B prepare and serve breakfast for licensee's residents in the dining room.

During an interview on October 31, 2022, at 10:45 a.m., ULP-B stated they were trained to administer medications and provide delegated treatment tasks to licensee residents

On November 1, 2022, at 10:18 a.m., licensed assisted living director (LALD)-C verified ULP-B's employee record lacked RN supervision for delegated tasks. LALD-C additionally stated all licensee's ULPs did not have supervision records for any delegated tasks performed. Also, LALD stated the licensee was working on implementing supervision tools to ensure all staff are regularly supervised.

The licensee's Supervision of Unlicensed Staff policy effective October 24, 2022, indicated unlicensed personnel will be supervised by designated supervisors to ensure that the staff is performing their job duties competently, and consistently with any professional standards that

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01440	Continued From page 39 may apply. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01540 SS=F	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one employee (unlicensed personal (ULP)-B) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01540		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE COTTAGE ASSISTED LIVING	1190 117TH AVENUE NW COON RAPIDS, MN 55448

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01540	Continued From page 40	01540		

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 November 1, 2022, at 8:40 a.m., the surveyor observed ULP-B prepare and serve breakfast for the licensee's residents in the dining room.

ULP-B started employment with licensee on May 27, 2020, under the comprehensive license, and started providing assisted living services on August 1, 2021.

ULP-B's employee record included dementia care training in the topics: activities, dressing and grooming, person centered care, management and abuse prevention, and problem solving for a total of seven and one half (7.5) hours.

ULP-B's employee record lacked completion of at least eight hours of initial dementia training on topics specified within 80 working hours of the employment start date.

On November 1, 2022, at 2:45 p.m., licensed assisted living director (LALD)-C verified ULP-B's training record lacked the required 8 hours of dementia care training and stated the licensee had discovered all the employees were having less than required dementia training hours. LALD-C also stated all employees have been assigned more lessons to record the required hours.

No further information was provided.

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01540	Continued From page 41 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days as required for one of one resident (R1).	01620		

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01620	Continued From page 42	01620		

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R1 was admitted to the licensee on October 31, 2021, with diagnoses including congestive heart failure, hypertension, and muscle weakness.

R1's Health Management Care Plan dated September 19, 2022, indicated R1 was receiving the following services: blood glucose monitoring, foot checks, shower, oxygen monitoring, monitor cardiovascular (blood pressure and heart rate) within normal parameters skin integrity and prevention of falls.

R1's record included Nursing Health and Safety Assessments dated March 3, 2022, June 3, 2022, and September 19, 2022, respectively. R1's assessments were over required the 90-day by two (2) days and 18 days respectively.

On November 1, 2022, at 12:10 p.m., registered nurse (RN)-A admitted all R1's 90-day assessments exceeded 90 days from previous assessments. RN-A stated the licensee used the same method to schedule the 90-day assessments and therefore all the licensee's resident assessments will be over the required 90-days from the previous ones.

The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2021, read

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01620	Continued From page 43 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 last date of the review. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (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:	01640		

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01640	Continued From page 44 Based on interview and record review, the licensee failed to ensure service plans were executed and included signatures or other authentication by the resident and 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on October 31, 2021, with diagnoses of congestive heart failure, hypertension, and muscle weakness. R1's Health Management Care Plan dated September 19, 2022, indicated R1 was receiving the following services: blood glucose monitoring, foot checks, shower, oxygen monitoring, monitor cardiovascular (blood pressure and heart rate) within normal parameters skin integrity and prevention of falls. R1's record lacked a written service plan to include all the services provided and a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. On November 1, 2022, licensed assisted living director (LALD)-C verified the licensee failed to execute a service plan with R1. LALD-C stated the licensee had not executed a service plan with	01640		

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01640	Continued From page 45 any of the other residents and that licensee was working to develop a service plan with all required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for three of three residents (R1, R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 On November 1, 2022, at 7:45 a.m., the surveyor observed ULP-D administer morning medications and check blood glucose for R1.	01820		

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R1 was admitted to the licensee on October 31, 2021, with diagnoses of congestive heart failure, hypertension, and muscle weakness.

R1's Health Management Care Plan dated September 19, 2022, indicated R1 was receiving the following services: blood glucose monitoring, foot checks, shower, oxygen monitoring, monitor cardiovascular (blood pressure and heart rate) within normal parameters skin integrity and prevention of falls.

R1's Medication Administration Record (MAR) dated October 2022, indicated medications administered to R1 daily from October 1, 2022, to October 31, 2022, included but were not limited to: atorvastatin 10 milligram (mg) tablets give one tablet by mouth at bed time, bumetanide 2 mg tablet give two tablets by mouth two times per day, glipizide extended release (ER) 2.5 mg tablet give one tablet by mouth one time daily, levothyroxine 25 microgram (mcg) tablet give one tablet by mouth daily on an empty stomach, metolazone 2.5 mg tablet give one tablet every other day maximum four doses, metolazone 5 mg tablet give one tablet by mouth three days a week (Monday, Wednesday, and Friday), metoprolol 25 mg tablets give one tablet by mouth daily at noon, and tramadol 50 mg tablets give one tablet by mouth three times a day.

R4
On November 1, 2022, at 8:20 a.m., the surveyor observed ULP-D administer morning medications to R4.

R4 was admitted to the licensee February 7, 2020, with diagnosis of paranoid schizophrenia.

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R4's Medication Administration Record (MAR) dated October 2022, indicated medications administered to R4 daily from October 1, 2022, to October 31, 2022, included but were not limited to: amlodipine atorvastatin 5-20 mg tablets give one tablet by mouth once daily, Eliquis 2.5 mg tablets give one tablet by mouth two times daily, haloperidol decanoate 100 mg/milliliter (ml) injection inject 75 mg intramuscular every four weeks, metformin hcl 500 mg tablets give one tablet by mouth daily, metoprolol 25 mg tablets give three tablets one time daily, and trazodone 50 mg tablet give one tablet at bed time.

R4's unsigned discharge orders printed June 29, 2022, indicated R4 was discharged with the following medications not all inclusive: haloperidol decanoate 100 mg/milliliter (ml) injection inject 75 mg intramuscular every four weeks, Abilify 400 mg extended release injection inject 400 mg intramuscular every 4 weeks, amlodipine atorvastatin 5-20 mg tablets give one tablet by mouth once daily, Eliquis 2.5 mg tablets give one tablet by mouth two times daily, ezetimibe 10 mg tablets take one tablet by mouth once daily and trazodone 50 mg tablet give one tablet at bed time.

R5
On November 1, 2022, at 8:08 a.m., the surveyor observed ULP-D administer morning medications to R5.

R5 was admitted to the licensee on March 27, 2017, with diagnosis of dementia.

R5's Medication Administration Record (MAR) dated October 2022, indicated medications administered to R5 daily from October 1, 2022, to October 31, 2022, included but were not limited

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01820	Continued From page 48 to: acetaminophen 500 mg tablet take two tablets by mouth twice daily, erythromycin 0.5% eye ointment give 0.5% two times daily, trazodone 25 mg tablet give one tablet at bed time, and senna 8.6 mg tablets give two tablets by mouth daily at 8 a.m. R1, R4, and R5's record lacked a current written or electronically recorded prescription for all prescribed medications that the assisted living facility was managing for the residents. On November 1, 2022, at 3:10 p.m., licensed assisted living director (LALD)-C confirmed R1, R4 and R5's records lacked a current written or electronically recorded prescription for all prescribed medications that the assisted living facility was managing for the residents. LALD-C stated the licensee did not have a system in place to track signed orders for all the medications licensee managed for the residents. The licensee's Medication and Treatment Orders policy effective October 21, 2022, indicated an order for medication or treatment must be dated, signed by the prescriber, and must be current and consistent with the resident's nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=E	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	01890		

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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 label medications with correct information, in addition the licensee failed to dispose of expired medications for three of five residents (R4, R5, R6) who received medication management services.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

PRESCRIPTION LABEL
On November 1, 2022, at approximately 10:10 a.m., the surveyor observed the medication cart and observed the following unlabeled medications:
- loperamide hydrochloride and simethicone tablets 2 milligram (mg)/125 mg
- Silvesorb gel (silver antimicrobial wound gel)
- amorphous hydrogel
- calcium 600 mg
- fish oil 1200 mg (Nature's Bounty)

On November 1, 2022, at approximately 10:25 a.m., registered nurse (RN)-A verified the

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01890	Continued From page 50 unlabeled medications in the medication cart and stated the licensee would label all medications. EXPIRED MEDICATIONS On November 1, 2022, at 10:31 a.m., the surveyor observed the memory care unit medication cart and observed the following expired medications: R4 - acetaminophen 325 mg expired August 1, 2022. - one touch delica plus lancets expired on December 27, 2021. R5 - polyethylene glycol powder 3350 mix 17 mg with 8 ounces of liquid expired on April 7, 2022. - artificial tears solution 1.4% three drops each eye expired April 17, 2022. R6 - polyethylene glycol powder 3350 mix 17 mg with 8 ounces of liquid expired on December 3, 2021. On September 27, 2022, at approximately 10:52 a.m., RN-A stated nursing destroyed expired medication monthly. In addition, a ULP would place an expired medication in the lower drawer of medication cart until nurse destroyed medication. The licensee's Storage of Medications policy dated October 21, 2022, indicated an over-the-counter drug must be kept in the original labeled container from the pharmacy and manufacture. In addition, medication would be kept in its original container bearing the original prescription label with legible information. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of	01940		

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01940	Continued From page 52 three residents (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 of the residents). The findings include: R1 was admitted to the licensee on October 31, 2021, with diagnoses of congestive heart failure, hypertension, and muscle weakness. R1's Health Management Care Plan dated September 19, 2022, indicated R1 was receiving the following services: blood glucose monitoring, foot checks, shower, oxygen monitoring, monitor cardiovascular (blood pressure and heart rate) within normal parameters skin integrity and prevention of falls. On November 1, 2022, at 7:45 a.m., the surveyor observed ULP-D administer morning medications and check blood glucose for R1. R1's record lacked a treatment or therapy management plan to include following content: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; - procedures for notifying a registered nurse or appropriate licensed health professional when a	01940		

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01940	Continued From page 53 problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received. On November 1, 2022, at 3:37 p.m., registered nurse (RN)-A verified R1's record lacked a treatment management plan with all required content. RN-A stated the licensee was aware all residents receiving treatments and/or therapy were lacking a treatment management plan, and all records will be updated to reflect the requirement. The licensee's Medications & Treatments policy reviewed October 21, 2022, indicated the assisted living facility would "develop and maintain a current individualized Medication and Treatment Management Plan based on the tenant's assessment." The policy further indicated the medication and treatment record must be kept current and updated with any changes. No further information is available. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or	01950		

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	24666	A. BUILDING: _____ B. WING _____	11/02/2022

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01950	Continued From page 54 assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific treatment instructions for each resident and documented those instructions in the resident's record for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 1, 2022, at 7:45 a.m., the surveyor observed ULP-D administer morning medications, check blood glucose and put on leg wraps for R1.	01950		

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01950	Continued From page 55 R1 was admitted to the licensee on October 31, 2021, with diagnoses of congestive heart failure, hypertension, and muscle weakness. R1's Health Management Care Plan dated September 19, 2022, indicated R1 was receiving the following services: blood glucose monitoring, foot checks, shower, oxygen monitoring, monitor cardiovascular (blood pressure and heart rate) within normal parameters skin integrity and prevention of falls. R1's Health Care Report dated October 10, 2022, through October 31, 2022, indicated R1's blood glucose reading values ranged between 121 molar concentration (mmol/L) and 376 mmol/L. R1's provider orders dated May 17, 2022, indicated start ace wraps for compression, on in a.m., off in the p.m. R1's discharge orders dated September 29, 2022, indicated 2 liters (L) via nasal cannula (NC) at night. On November 1, 2022, at 2:39 p.m., RN-A stated treatment service documentation was done on the service delivery record or medication administration record (MAR) and verified there was no treatment administration record (TAR) for treatment instructions or documentation. RN-A acknowledged the records lacked specific instructions related to the delegated treatment services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatment administration for one of two residents (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: On November 1, 2022, at 7:45 a.m., the surveyor observed ULP-D administer morning medications, check blood glucose, and put on leg Ace wraps for R1. R1 was admitted to the licensee on October 31, 2021, with diagnoses of congestive heart failure,	01960		

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01960	Continued From page 57 hypertension, and muscle weakness. R1's Health Management Care Plan dated September 19, 2022, indicated R1 was receiving the following services: blood glucose monitoring, foot checks, shower, oxygen monitoring, monitor cardiovascular (blood pressure and heart rate) within normal parameters skin integrity and prevention of falls. R1's provider orders dated May 17, 2022, indicated start ace wraps for compression, on in a.m., off in the p.m. R1's discharge orders dated September 29, 2022, indicated 2 liters (L) via nasal cannula (NC) at night. R1's record lacked documentation for application of the following treatments: ace wraps and oxygen. On November 1, 2022, at 12:45 p.m., licensed assisted living director (LALD)-C confirmed R1's record lacked documentation of ace wraps and oxygen. LALD-C stated the licensee's RN will initiate documentation immediately. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a	01970		

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01970	Continued From page 58	01970		

description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R1) receiving treatments.

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:

During the entrance conference on November 1, 2022, at 9:35 a.m., licensed assisted living director (LALD)-C and registered nurse (RN)-A confirmed the licensee provided treatment ant therapy services to residents.

On November 1, 2022, at 7:45 a.m., the surveyor observed ULP-D administer morning medications, check blood glucose, and put on leg ace wraps for R1.

R1 was admitted to the licensee on October 31, 2021, with diagnoses of congestive heart failure, hypertension, and muscle weakness.

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01970	Continued From page 59 R1's Health Management Care Plan dated September 19, 2022, indicated R1 was receiving the following services: blood glucose monitoring, foot checks, shower, oxygen monitoring, monitor cardiovascular (blood pressure and heart rate) within normal parameters skin integrity and prevention of falls. R1's record lacked written or electronically recorded order from an authorized prescriber for blood glucose. On November 1, 2022, at 1:30 p.m., RN-A verified R1's record lacked prescriber's orders for the above treatment. RN-A stated they will call provider to receive the orders and parameters for the treatment/therapy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.	02040		

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02040	Continued From page 60 This MN Requirement is not met as evidenced by: Based on the document review and interview, the licensee failed to develop a hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff, visitors, and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On November 1, 2022, at approximately 2:45 p.m., a documentation review and interview were performed with the licensed assisted living facility (LALD)-C on the hazard vulnerability assessment and mitigation plan for the memory care physical environment of the property. During the interview, the LALD-C stated that they had not developed the hazard vulnerability assessment and mitigation plan on and around the property to protect the memory care residents from harm. This finding was evident as there was no plan documentation was provided for review. On November 1, 2022, at approximately 3:00 p.m., at the interview, the LALD-C acknowledged that the licensee did not have a documented	02040		

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02040	Continued From page 61 hazard vulnerability assessment plan. Additionally, LALD-C stated the licensee will develop a plan to reflect the requirement and contact survey staff with any additional questions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and	02110		

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02110	Continued From page 62	02110		

intercom systems for emergencies and evacuation drills only;
(9) transportation coordination and assistance to and from outside medical appointments; and
(10) safekeeping of residents' possessions.
(b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care were provided to residents and the residents legal and designated representatives at the time of move-in 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 of the residents).

The findings include:

R1 was admitted to the licensee on October 31, 2021, with diagnoses of congestive heart failure, hypertension, and muscle weakness.

R1's Health Management Care Plan dated September 19, 2022, indicated R1 was receiving the following services: blood glucose monitoring, foot checks, shower, oxygen monitoring, monitor cardiovascular (blood pressure and heart rate) within normal parameters skin integrity and

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02110	Continued From page 63 prevention of falls. R1's record lacked evidence to have received required policies and procedures for assisted living with dementia care. On November 1, 2022, at 3:50 p.m., licensed assisted living director (LALD)-C verified R1 and all the licensee's residents and the residents' legal and designated representatives did not receive the required dementia care policies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02140		

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02140	Continued From page 64 safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 31, 2022, at 9:50 a.m., licensed assisted living director (LALD)-C stated the licensee had a designated person who oversaw training of staff in the care of individuals with dementia. On October 31, 2022, at 10:00 a.m., the surveyor requested the designated person's skills competency or knowledge test required by the commissioner. On November 2, 2022, by the exit time at 9:40 a.m., the licensee had not provided the requested skills competency or knowledge test required by the commissioner. The licensee's undated Training Requirement for Assisted Living with Dementia Care policy indicated supervisors of direct-care staff must have at least eight hours of initial training on topics specified per statute within 120 working hours of the employment start date; direct-care employees must have completed at least eight hours of initial training on topics specified within 160 working hours of the employment start date. No further information was provided. TIME PERIOD TO CORRECT: Twenty-One (21) days	02140		

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02240	Continued From page 65	02240		
02240 SS=F	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate	02240		

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02240	Continued From page 66 because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received 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 of the residents). The findings include: R1 was admitted to the licensee on October 31, 2021, with diagnoses of congestive heart failure, hypertension, and muscle weakness. R1's record lacked evidence resident received a current assisted living bill of rights, or a written acknowledgement, and the process for filing a complaint. On November 1, 2022, at 2:50 p.m., licensed assisted living director (LALD)-C confirmed R1 and/or representative had not received a current	02240		

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02240	Continued From page 67 assisted living bill of rights. LALD-C stated none of the other residents had an acknowledgment on file for the same. Further, LALD-C stated the licensee was aware and working to have all residents receive and sign acknowledgment for current assisted living bill of rights. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240		
02310 SS=D	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 standards, medical or nursing standards for one of one resident (R1) who utilized oxygen therapy. 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).	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24666	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE COTTAGE ASSISTED LIVING	1190 117TH AVENUE NW COON RAPIDS, MN 55448

(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 68 The findings include: R1's diagnoses included the following: congestive heart failure, hypertension, and muscle weakness. R1's Health Management Care Plan dated September 19, 2022, indicated R1 was receiving the following services: blood glucose monitoring, foot checks, shower, oxygen monitoring, monitor cardiovascular (blood pressure and heart rate) within normal parameters skin integrity and prevention of falls. R1's discharge orders dated September 29, 2022, indicated 2 liters (L) of oxygen via nasal cannula (NC) at night. R1's hospital discharge summary lacked oxygen parameters. On November 1, 2022, at approximately 8:20 a.m., in R1's room the surveyor observed three compressed oxygen tanks: two at the foot of the bed and one by the main door of R1's room, and two oxygen concentrators: all by the two oxygen tanks at the foot of the bed. The compressed oxygen tank by the door was standing on the floor without a secured stand. On November 1, 2022, at 10:10 a.m., registered nurse (RN)-A acknowledged the unsecured compressed oxygen tank was not safe and stated the licensee will request the oxygen vendor to remove the tanks and concentrators that are not in use from the resident room. The Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 20, 2020, indicated a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. Oxygen cylinders must be	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24666	A. BUILDING: _____ B. WING _____	11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE COTTAGE ASSISTED LIVING	1190 117TH AVENUE NW COON RAPIDS, MN 55448

(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 69 secured (chains or racks) to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *10/31/22*
Time: 14:30:26
Report: 1018221176

Food and Beverage Establishment Inspection Report

Location:
Creekside Cottage Assist Liv
1190 117th Avenue Nw
Coon Rapids, MN55448
Anoka County, 02

Establishment Info:
ID #: 0038640
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637546899
ID #:

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

The following orders were issued during this inspection.

3-500C 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.

DELI MEATS AND CHEESES IN THE COOLER WERE OBSERVED WITHOUT DATE MARKS. COMPLY WITH RULE.

Comply By: 10/31/22

2-100 Supervision

2-102.12AMN

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

CURRENT CERTIFIED FOOD MANAGER CERTIFICATE IS EXPIRED. COMPLY WITH RULE.

Comply By: 01/02/23

Food and Equipment Temperatures

Process/Item: Cold Holding/ DELI MEAT
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cold Holding/ CHEESE
Temperature: 40 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Type: Full
Date: *10/31/22*
Time: 14:30:26
Report: 1018221176
Creekside Cottage Assist Liv

Food and Beverage Establishment Inspection Report

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

DISCUSSED EMPLOYEE ILLNESS POLICY.

PHYSICAL FACILITIES OBSERVED IN GOOD CONDITION.

DISHWASHER OBSERVED WITH SANITIZING FUNCTION.

FIRM DOES ONLY SAME DAY SERVICE OF FOODS.

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

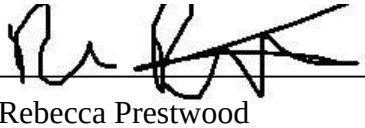
I acknowledge receipt of the Minnesota Department of Health inspection report number 1018221176 of 10/31/22.

Certified Food Protection Manager: JOHN P POLITTE

Certification Number: FM7604 Expires: 09/26/22

Inspection report reviewed with person in charge and emailed.

Signed: _____
MELISSA JUNGELS
MANAGER

Signed: 
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