*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

April 1, 2025

Licensee
Cedar Crest of Silver Lake
1401 Main Street West
Silver Lake, MN  55381

RE:  Project Number(s) SL26903016

Dear Licensee:

On February 28, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on November 14, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the November 14, 2024 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 14, 2024, found not corrected at the time of the February 28, 2025, follow-up survey and/or subject to penalty assessment are as follows:

**1060-Emergency Relocation-144g.52 Subd. 9**
**1690-Medication Management Services-144g.71 Subdivision 1 - $500.00**
**1700-Provision Of Medication Management Services-144g.71 Subd. 2 - $500.00**
**1710-Individualized Medication Monitoring And Reas-144g.71 Subd. 3 - $500.00**
**1730-Individualized Medication Management Plan-144g.71 Subd. 5 - $500.00**
**1930-Policies And Procedures-144g.72 Subd. 2 - $500.00**

The details of the violations noted at the time of this follow-up survey completed on February 28, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on February 28, 2025, we identified the following violation(s):

**0340-Correction Orders-144g.30 Subd. 5 - $500.00**

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

**IMPOSITION OF FINES:**

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.

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

Sincerely,



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

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 26903 | A. BUILDING: _____ B. WING _____ | R 02/28/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

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| {0 000} | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS<br><br>INITIAL COMMENTS<br>SL26903016-1<br><br>On February 24, 2025, and February 28, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on November 14, 2024. At the time of the survey, there were 38 residents; all receiving services under the provider's Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were reissued. | {0 000} | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 340 SS=F | 144G.30 Subd. 5 Correction orders<br><br>(a) A correction order may be issued whenever | 0 340 | | |

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| 0 340 | Continued From page 1<br>the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction.<br>(b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically.<br>(c) By the correction order date, the facility must:<br>(1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a revisit survey completed on November 14, 2024.<br><br>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 | 0 340 | | |

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| 0 340 | Continued From page 2<br>or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On February 24, 2025, at 10:21 a.m., clinical nurse supervisor (CNS)-A stated she felt most of the corrections had been made.<br><br>During the revisit survey on February 24, 2025, and February 28, 2025, the surveyor reviewed the licensee's policies and procedures, resident records, employee records and conducted interviews with licensed assisted living director (LALD)-D and CNS-A. The licensee lacked evidence to indicate all of the orders issued on November 14, 2024, were corrected.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 340 | | |
| {0 480} SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and | {0 480} | | |

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| {0 480} | Continued From page 3<br>supervise each facility's food service operation;<br>(2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;<br>(3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;<br>(4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;<br>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;<br>(6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. | {0 480} | | |

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| {0 480} | Continued From page 4<br>This MN Requirement is not met as evidenced by: | {0 480} | Not reviewed during this survey. | |
| {0 780} SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and<br>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;<br><br>This MN Requirement is not met as evidenced by: | {0 780} | Not reviewed during this survey. | |
| {0 800} SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment | {0 800} | | |

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| {0 800} | Continued From page 5<br>(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.<br><br>This MN Requirement is not met as evidenced by: | {0 800} | Not reviewed during this survey. | |
| {0 810} SS=F | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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 | {0 810} | | |

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| {0 810} | Continued From page 6<br>include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.<br>(f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by: | {0 810} | Not reviewed during this survey. | |
| {01060} SS=D | 144G.52 Subd. 9 Emergency relocation<br><br>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;<br>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>(5) a statement that, if the facility refuses to | {01060} | | |

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| {01060} | Continued From page 7<br><br>provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and<br>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.<br>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of two residents (R9) whom was hospitalized.<br><br>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).<br><br>The findings include: | {01060} | | |

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| {01060} | Continued From page 8<br><br>R9's diagnoses included chronic kidney disease, major depressive disorder, and urinary tract symptoms.<br><br>R9's Service Plan Agreement, dated December 5, 2024, indicated R9 received services including weekly vital signs, appointment management, meal supervision, bathing assistance, medication management and administration, wellness checks, housekeeping and laundry.<br><br>R9's Progress Notes included:<br>- January 22, 2025, at 8:24 a.m., R9 had an unwitnessed fall during the night at 2:10 a.m. R9 had a low grade fever for approximately two days and oxygen levels were lower than usual, from 80-91 %. Lungs sounds were diminished and wheezy, pulse was elevated. Power of attorney was notified and requested to have R9 sent to hospital;<br>- January 22, 2025, at 2:31 p.m., R9 was admitted with diagnosis of asthmatic bronchitis; and<br>- January 23, 2025, at 3:05 p.m., R9 returned to the facility from the hospital.<br><br>R9's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum:<br>- the reason for the relocation;<br>- the name and contact information for the location to which the resident had been relocated and any new service provider;<br>- contact information for the Office of Ombudsman for Long-Term Care (OOLTC);<br>- if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and | {01060} | | |

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| {01060} | Continued From page 9<br>- a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal.<br><br>On February 24, 2025, at 1:07 p.m., clinical nurse supervisor (CNS)-A stated she understood the emergency relocation notice was only required if the resident was hospitalized for three days.<br><br>No further information was provided. | {01060} | | |
| {01690} SS=F | 144G.71 Subdivision 1 Medication management services<br><br>(a) This section applies only to assisted living facilities that provide medication management services.<br>(b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.<br>(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused | {01690} | | |

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| {01690} | Continued From page 10<br><br>medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures under the supervision and direction of a registered nurse (RN).<br><br>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).<br><br>The findings include:<br><br>On February 24, 2025, at 10:21 a.m., clinical nurse supervisor (CNS)-A, licensed assisted living director (LALD)-D, and owner (O)-B stated the licensee provided medication management services to the licensee's residents.<br><br>During the revisit survey on February 24, 2025, and February 28, 2025, the surveyor reviewed the licensee's policies and procedures and conducted interviews with CNS-A. | {01690} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

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| {01690} | Continued From page 11<br><br>The licensee continued to lack policies and procedures that addressed:<br>- monitoring and evaluating medication use; and<br>- educating residents and legal and designated representatives about medications.<br><br>On February 24, 2025, at 3:28 p.m., CNS-A stated she was waiting for the company that provided their electronic medical record (EMR) to update the licensee's program to include the required information for the medication and treatment management assessment and plan, and she would then update the policies to include the required information. CNS-A stated this had not been completed at this time.<br><br>No further information was provided. | {01690} | | |
| {01700} SS=F | 144G.71 Subd. 2 Provision of medication management services<br><br>(a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.<br>(b) The assessment must identify interventions | {01700} | | |

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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

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| {01700} | Continued From page 12<br><br>needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the required content for one of one resident (R1).<br><br>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).<br><br>The findings include:<br><br>During the revisit survey on February 24, 2025, at 10:21 a.m., clinical nurse supervisor (CNS)-A, licensed assisted living director (LALD)-D, and owner (O)-B stated the licensee provided medication management services to the licensee's residents.<br><br>R1's diagnoses included Parkinson's disease, type II diabetes, and anxiety. | {01700} | | |

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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

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| {01700} | Continued From page 13<br><br>R1's Service Plan Agreement, dated August 22, 2024, indicated R1 received services including range of motion exercises, compression garment, managing appointments, monitoring supplies, assistance with wheeling, socialization, activities, bathing assistance, grooming, dining reminders and escort, dressing, compression stockings, physical assist of one with ambulation and transfers as needed, toileting assistance, medication administration, blood sugar checks once daily, skin monitoring, housekeeping and laundry.<br><br>R1's Master Assessment, dated August 26, 2024, identified as 90 day assessment, indicated under Medication Assistance, R1 used the house pharmacy, and under Medication Management, R1 utilized the central storage of medications due to request and/or diagnosis.<br><br>R1's prescriber orders included a mild pain reliever, medication to prevent heart attack or stroke, two supplements, medication used to treat symptoms of Parkinson's disease, medication to decrease fluid excess, sleep aid, medication to treat diabetes, treat high blood pressure, treat constipation, and treat high cholesterol.<br><br>R1's Medication Administration Record (MAR), dated November 1, 2024, through November 13, 2024, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given.<br><br>R1's record lacked evidence the RN had conducted a medication assessment to include:<br>- identification and review of all medications the resident is known to be taking;<br>- must be conducted face to face;<br>- indications for medications; | {01700} | | |

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| {01700} | Continued From page 14<br>- side effects;<br>- contraindications;<br>- allergic or adverse reactions, and actions to address these issues; and<br>- identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.<br><br>On February 24, 2025, at 3:28 p.m., CNS-A stated the medication assessments remained the same and had not changed since the initial survey. CNS-A stated, following the initial survey and receiving citations for lacking the above content in the medication assessment, she contacted the licensee's software company that provided their electronic medical record (EMR). CNS-A provided email documentation, dated November 20, 2024, from the software provider, with examples of items that could be added to the medication assessment to ensure compliance. CNS-A emailed the software company on December 9, 2024, confirming the information the licensee wanted to add and asked for the cost to add this to their current program. The software company responded on December 13, 2024, with a cost estimate, indicating the implementation team would add the information to the database once CNS-A approved. The next email communication provided was on January 29, 2025, from the software company, indicating the implementation team would get started creating the assessment, with a tentative time frame for completion February 7, 2025. CNS-A emailed the software company on February 18, 2025, requesting an update on the assessments as they | {01700} | | |

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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

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| {01700} | Continued From page 15<br><br>had not received the updated assessment. An email was received from the software company on February 24, 2025, at 11:56 a.m., indicating the assessments should be completed on February 26, 2025.<br><br>No further information was provided. | {01700} | | |
| {01710} SS=F | 144G.71 Subd. 3 Individualized medication monitoring and reas<br><br>The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for three of three residents (R1, R2, R3) who received medication management services.<br><br>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).<br><br>The findings include: | {01710} | | |

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| {01710} | Continued From page 16<br><br>During the revisit survey on February 24, 2025, at 10:21 a.m., clinical nurse supervisor (CNS)-A, licensed assisted living director (LALD)-D, and owner (O)-B stated the licensee provided medication management services to the licensee's residents.<br><br>R1<br>R1's diagnoses included Parkinson's disease, type II diabetes, and anxiety.<br><br>R1's Service Plan Agreement, dated August 22, 2024, indicated R1 received services including medication management and administration.<br><br>R1's Master Assessment, dated August 26, 2024, identified as 90 day assessment, indicated under Medication Assistance, R1 used the house pharmacy, and under Medication Management, R1 utilized the central storage of medications due to request and/or diagnosis.<br><br>R1's prescriber orders, printed on November 13, 2024, included a mild pain reliever, medication to prevent heart attack or stroke, two supplements, medication used to treat symptoms of Parkinson's disease, medication to decrease fluid excess, sleep aid, medication to treat diabetes, treat high blood pressure, treat constipation, and treat high cholesterol.<br><br>R1's Medication Administration Record (MAR), dated November 1, 2024, through November 13, 2024, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given.<br><br>R1's record included a MN (Minnesota) Medication Treatment Therapy Management Plan, dated September 20, 2022. | {01710} | | |

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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

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| {01710} | Continued From page 17<br><br>R1's record did not include an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking, including a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion.<br><br>R2<br>R2's diagnoses included Parkinson's disease, anxiety disorder, and dementia with mood disturbance.<br><br>R2's Service Plan Agreement, dated August 10, 2023, indicated R2 received services including medication management and administration.<br><br>R2's Master Assessment, dated August 16, 2024, identified as 90 day assessment, indicated under Medication Assistance, R2 used the house pharmacy, and under Medication Management, R2 utilized the central storage of medications due to request and/or diagnosis.<br><br>R2's prescriber orders, printed on November 13, 2024, included an antianxiety, two medications to treat symptoms of Parkinson's disease, medication to treat high blood pressure, mild pain reliever, medication to treat low thyroid hormone, medication to reduce stomach acid, an antidepressant, an antipsychotic, and a supplement.<br><br>R2's MAR, dated November 1, 2024, through November 12, 2024, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given. | {01710} | | |

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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

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| {01710} | Continued From page 18<br><br>R2's record included a MN Medication Treatment Therapy Management Plan, dated August 8, 2023.<br><br>R2's record did not include an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking, including a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion.<br><br>R3<br>R3's diagnoses included multiple sclerosis (an autoimmune disease that affects the brain and spinal cord), chronic fatigue, and mild cognitive impairment.<br><br>R3's Service Plan Agreement, dated July 9, 2024, indicated R3 received services including medication management and administration.<br><br>R3's Master Assessment, dated October 8, 2024, identified as 90 day assessment, indicated under Medication Assistance, R3 used the house pharmacy, and under Medication Management, R3 utilized the central storage of medications due to request and/or diagnosis.<br><br>R3's prescriber orders, dated January 8, 2024, included a medication to treat muscle spasms, medication to decrease fluid excess, mild pain reliever, medication to treat low thyroid hormone, medication to treat pain from nerve damage, a stool softener, and a supplement.<br><br>R3's MAR, dated November 1, 2024, through November 13, 2024, listed medications as | {01710} | | |

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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

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| {01710} | Continued From page 19<br><br>prescribed, times to be administered, and staff initials on each date to indicate the medications had been given.<br><br>R3's record included a MN Medication Treatment Therapy Management Plan, dated February 11, 2022.<br><br>R3's record did not include an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including, a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion.<br><br>On February 24, 2025, at 3:28 p.m., CNS-A stated the medication assessments remained the same and had not changed since the initial survey. CNS-A stated, following the initial survey and receiving citations for lacking the above content in the medication assessment, she contacted the licensee's software company that provided their electronic medical record (EMR). CNS-A provided email documentation, dated November 20, 2024, from the software provider, with examples of items that could be added to the medication assessment to ensure compliance. CNS-A emailed the software company on December 9, 2024, confirming the information the licensee wanted to add and asked for the cost to add this to their current program. The software company responded on December 13, 2024, with a cost estimate, indicating the implementation team would add the information to the database once CNS-A approved. The next email communication provided was on January 29, 2025, from the software company, indicating the implementation team would get started creating | {01710} | | |

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| {01710} | Continued From page 20<br><br>the assessment, with a tentative time frame for completion February 7, 2025. CNS-A emailed the software company on February 18, 2025, requesting an update on the assessments as they had not received the updated assessment. An email was received from the software company on February 24, 2025, at 11:56 a.m., indicating the assessments should be completed on February 26, 2025.<br><br>No further information was provided. | {01710} | | |
| {01730} SS=F | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered | {01730} | | |

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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

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| {01730} | Continued From page 21<br><br>nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop an individualized medication management plan prior to providing medication management services, and with the required content, for three of three residents (R1, R2, R3).<br><br>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).<br><br>The findings include:<br><br>During the revisit survey on February 24, 2025, at 10:21 a.m., clinical nurse supervisor (CNS)-A, licensed assisted living director (LALD)-D, and | {01730} | | |

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| {01730} | Continued From page 22<br><br>owner (O)-B stated the licensee provided medication management services to the licensee's residents.<br><br>R1<br>R1's diagnoses included Parkinson's disease, type II diabetes, and anxiety.<br><br>R1's Service Plan Agreement, dated August 22, 2024, indicated R1 received services including medication management and administration.<br><br>R1's Master Assessment, dated August 26, 2024, identified as 90 day assessment, indicated under Medication Assistance, R1 used the house pharmacy, and under Medication Management, R1 utilized the central storage of medications due to request and/or diagnosis. The assessment lacked a medication management assessment.<br><br>R1's prescriber orders, printed on November 13, 2024, included a mild pain reliever, medication to prevent heart attack or stroke, two supplements, medication used to treat symptoms of Parkinson's disease, medication to decrease fluid excess, sleep aid, medication to treat diabetes, treat high blood pressure, treat constipation, and treat high cholesterol.<br><br>R1's Medication Administration Record (MAR), dated November 1, 2024, through November 13, 2024, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given.<br><br>R1's record included a MN (Minnesota) Medication Treatment Therapy Management Plan, dated September 20, 2022. The plan indicated the licensee would provide administration of medications, medications would | {01730} | | |

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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

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| {01730} | Continued From page 23<br><br>be securely stored by the licensee in the locked medication cart and accessed by licensee staff, and community staff would monitor supplies and would coordinate refills. R1's record lacked a current individualized medication management plan, based on the resident's assessment, to include the following required content:<br>- a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>- documentation of specific resident instructions relating to the administration of medications;<br>- identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>- identification of medication management tasks that may be delegated to unlicensed personnel;<br>- procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>- any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br><br>R2<br>R2's diagnoses included Parkinson's disease, anxiety disorder, and dementia with mood disturbance.<br><br>R2's Service Plan Agreement, dated August 10, 2023, indicated R2 received services including medication management and administration.<br><br>R2's Master Assessment, dated August 16, 2024, identified as 90 day assessment, indicated under | {01730} | | |

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| {01730} | Continued From page 24<br><br>Medication Assistance, R2 used the house pharmacy, and under Medication Management, R2 utilized the central storage of medications due to request and/or diagnosis.<br><br>R2's prescriber orders, printed on November 13, 2024, included an antianxiety, two medications to treat symptoms of Parkinson's disease, medication to treat high blood pressure, mild pain reliever, medication to treat low thyroid hormone, medication to reduce stomach acid, an antidepressant, an antipsychotic, and a supplement.<br><br>R2's MAR, dated November 1, 2024, through November 12, 2024, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given.<br><br>R2's record included a MN Medication Treatment Therapy Management Plan, dated August 8, 2023. The plan indicated the licensee would provide administration of medications, medications would be securely stored by the licensee in the locked medication cart and accessed by licensee staff, and community staff would monitor supplies and would coordinate refills. R2's record lacked a current individualized medication management plan, based on the resident's assessment, to include the following required content:<br>- a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>- documentation of specific resident instructions relating to the administration of medications;<br>- identification of persons responsible for monitoring medication supplies and ensuring that | {01730} | | |

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| {01730} | Continued From page 25<br><br>medication refills are ordered on a timely basis;<br>- identification of medication management tasks that may be delegated to unlicensed personnel;<br>- procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>- any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br><br>R3<br>R3's diagnoses included multiple sclerosis (an autoimmune disease that affects the brain and spinal cord), chronic fatigue, and mild cognitive impairment.<br><br>R3's Service Plan Agreement, dated July 9, 2024, indicated R3 received services including medication management and administration.<br><br>R3's Master Assessment, dated October 8, 2024, identified as 90 day assessment, indicated under Medication Assistance, R3 used the house pharmacy, and under Medication Management, R3 utilized the central storage of medications due to request and/or diagnosis.<br><br>R3's prescriber orders, dated January 8, 2024, included a medication to treat muscle spasms, medication to decrease fluid excess, mild pain reliever, medication to treat low thyroid hormone, medication to treat pain from nerve damage, a stool softener, and a supplement.<br><br>R3's MAR, dated November 1, 2024, through November 13, 2024, listed medications as | {01730} | | |

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| {01730} | Continued From page 26<br><br>prescribed, times to be administered, and staff initials on each date to indicate the medications had been given.<br><br>R3's record included a MN Medication Treatment Therapy Management Plan, dated February 11, 2022. The plan indicated the licensee would provide administration of medications, medications would be securely stored by the licensee in the locked medication cart and accessed by licensee staff, and community staff would monitor supplies and would coordinate refills. R3's record lacked a current individualized medication management plan, based on the resident's assessment, to include the following required content:<br>- a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>- documentation of specific resident instructions relating to the administration of medications;<br>- identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>- identification of medication management tasks that may be delegated to unlicensed personnel;<br>- procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>- any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br><br>On February 24, 2025, at 3:28 p.m., CNS-A stated the medication management plans | {01730} | | |

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| {01730} | Continued From page 27<br><br>remained the same and had not changed since the initial survey. CNS-A stated, following the initial survey and receiving citations for lacking the above content in the medication management plans, she contacted the licensee's software company that provided their electronic medical record (EMR). CNS-A provided email documentation, dated November 20, 2024, from the software provider, with examples of items that could be added to the medication management plan to ensure compliance. CNS-A emailed the software company on December 9, 2024, confirming the information the licensee wanted to add and asked for the cost to add this to their current program. The software company responded on December 13, 2024, with a cost estimate, indicating the implementation team would add the information to the database once CNS-A approved. The next email communication provided was on January 29, 2025, from the software company, indicating the implementation team would get started creating the medication management plan, with a tentative time frame for completion February 7, 2025. CNS-A emailed the software company on February 18, 2025, requesting an update as they had not received the updated information. An email was received from the software company on February 24, 2025, at 11:56 a.m., indicating the information should be completed on February 26, 2025.<br><br>No further information was provided. | {01730} | | |
| {01930} SS=F | 144G.72 Subd. 2 Policies and procedures<br><br>(a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy | {01930} | | |

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| {01930} | Continued From page 28<br><br>management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines.<br>(b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines.<br><br>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).<br><br>The findings include:<br><br>On February 24, 2025, at 10:21 a.m., clinical nurse supervisor (CNS)-A, licensed assisted | {01930} | | |

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| {01930} | Continued From page 29<br><br>living director (LALD)-D, and owner (O)-B stated the licensee provided treatment management services.<br><br>During the revisit survey on February 24, 2025, and February 28, 2025, the surveyor reviewed the licensee's policies and procedures and conducted interviews with CNS-A.<br><br>The licensee continued to lack policies and procedures that addressed:<br>- educating and communicating with residents about treatments or therapies they are receiving; and<br>- monitoring and evaluating the treatment or therapy.<br><br>On February 24, 2025, at 3:28 p.m., CNS-A stated she was waiting for the company that provided their electronic medical record (EMR) to update the licensee's program to include the required information for the medication and treatment management assessment and plan, and she would then update the policies to include the required information. CNS-A stated this had not been completed at this time.<br><br>No further information was provided. | {01930} | | |

Electronically Delivered

December 19, 2024

Licensee
Cedar Crest of Silver Lake
1401 Main Street West
Silver Lake, MN  55381

RE:  Project Number(s) SL26903016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 14, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

**STATE CORRECTION ORDERS**

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

**IMPOSITION OF FINES**

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

Level 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.

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

**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00**
**St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00**
**St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,



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

HHH

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL26903016-0<br><br>On November 12, 2024, through November 14, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 40 residents; all receiving services under the provider's Assisted Living with Dementia Care license.<br><br>Immediate correction orders were identified on November 13, 2024, for project number SL26903016, tag identifications 1290 and 2070, both issued at level three, widespread scope (l). | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services | 0 480 | | |

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

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| 0 480 | Continued From page 2<br><br>allowed provided the facility keeps them clean and in good condition;<br>(6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 12, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |

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| 0 485 SS=C | 144G.41 Subdivision 1.a (a) Minimum requirements; required food services<br><br>All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure a menu was prepared a week in advance and made available to the residents. This had the potential to affect all residents.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On November 13, 2024, at 11:55 a.m., the | 0 485 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

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| 0 485 | Continued From page 4<br><br>surveyor observed a menu on the board in the residents' dining room. Community coordinator (CC)-M stated the menu was posted on Sunday, and included the meals for Monday, Tuesday, Wednesday, and Thursday, and then on Thursday, a new menu was posted for Friday, Saturday, and Sunday. CC-M stated, although the menu was prepared in advance, the menu was not made available to the residents at least a week in advance, as required.<br><br>The licensee's Diet and Meals policy, effective May 7, 2017, indicated menus would be provided in a safe, timely manner and menus would be evaluated to ensure nutritional needs were met; however, the policy did not indicate menus would be made available to all residents at least one week in advance, as required.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 485 | | |
| 0 500 SS=F | 144G.41 Subd. 2 Policies and procedures<br><br>Each assisted living facility must have policies and procedures in place to address the following and keep them current:<br>(1) requirements in section 626.557, reporting of maltreatment of vulnerable adults;<br>(2) conducting and handling background studies on employees;<br>(3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance;<br>(4) handling complaints regarding staff or services provided by staff;<br>(5) conducting initial evaluations of residents' | 0 500 | | |

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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

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| 0 500 | Continued From page 5<br><br>needs and the providers' ability to provide those services;<br>(6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate;<br>(7) orientation to and implementation of the assisted living bill of rights;<br>(8) infection control practices;<br>(9) reminders for medications, treatments, or exercises, if provided;<br>(10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards;<br>(11) ensuring that nurses and licensed health professionals have current and valid licenses to practice;<br>(12) medication and treatment management;<br>(13) delegation of tasks by registered nurses or licensed health professionals;<br>(14) supervision of registered nurses and licensed health professionals; and<br>(15) supervision of unlicensed personnel performing delegated tasks.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required. | 0 500 | | |

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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

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| 0 500 | Continued From page 6<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on November 12, 2024, at 10:20 a.m., owner (O)-B, clinical nurse supervisor (CNS)-A, licensed assisted living director (LALD)-D, and licensed practical nurse (LPN)-C, stated they accessed the assisted living regulations online.<br><br>On November 14, 2024, at 12:20 p.m., licensed assisted living director (LALD)-D provided the licensee's Bill of Rights policy, dated August 1, 2014. The policy included information regarding the Minnesota Home Care Bill of Rights, indicating the licensee would provide the client (resident) or the client's representative a written copy of the Minnesota Home Care Bill of Rights before the initiation of services to the client.<br><br>The licensee failed to ensure the following policies and procedures were in place and kept current:<br>- orientation to and implementation of the assisted living bill of rights.<br><br>On November 14, 2024, at 12:23 p.m., LALD-D stated she didn't realize the policy had not been updated when the licensee began providing assisted living services on August 1, 2021. | 0 500 | | |

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| 0 500 | Continued From page 7<br><br>The licensee's Policy Review and Revision policy, dated July 28, 2021, indicated the licensee would review the company Policy and Procedure Book at least annually and as needed to make sure policies were up to date.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 500 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of one employee (unlicensed personnel (ULP)-J) observed to provide personal cares.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 510 | | |

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| 0 510 | Continued From page 8<br><br>safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On November 13, 2024, at 6:14 a.m., with R3's permission, the surveyor observed ULP-J while transferring R3 with a sit-to-stand lift, from the bed to the wheelchair, and then into the bathroom, and onto the toilet. ULP-J donned (put on) gloves. When R3 announced she was finished, ULP-J used the sit-to-stand lift to assist R3 to a standing position, and used a towel to clean R3's bottom. ULP-J removed the gloves and tossed them into the trash. Without performing hand hygiene, ULP-J pushed the lift with R3 out of the bathroom, touching the handles of the lift an the controls for the lift to assist R3 into the wheelchair, straightened R3's bed sheets, and touched several items in R3's room while tidying the room. ULP-J donned a glove on her right hand, picked up the soiled towel and the garbage bag with her ungloved left hand, reached into her pocket with her gloved right hand to retrieve her pager and then placed the phone back into her pocket. ULP-J opened R3's door that led into the hallway with the ungloved left hand while holding the soiled towel and garbage bag, walked back into the room to give R3 a speaker that was out of her reach, doffed (took off) the glove on her right hand, and walked out of R3's room into the hallway. ULP-J disposed of the soiled items and walked into the nurse's office, stating she was now off duty and would be leaving. Without performing hand hygiene, ULP-J opened a drawer, reached into her pocket for the | 0 510 | | |

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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

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| 0 510 | Continued From page 9<br><br>pager, placed it in the drawer, and prepared to leave the facility.<br><br>On November 13, 2024, at 6:49 a.m., when asked at what point she should perform hand hygiene, ULP-J stated, "In there? I used the gloves," when assisting R3, and stated she couldn't use hand sanitizer because it bothered her hands. ULP-J stated she usually washed her hands between caring for residents, but her shift was finished and she was going to be leaving. With encouragement, ULP-J washed her hands in the sink in the nurse's office, and stated, "I see what you mean." ULP-J stated she remembered something about washing her hands after removing gloves, when she received her initial training, but stated had worked in the facility for several years.<br><br>On November 13, 2024, at 8:18 a.m., clinical nurse supervisor (CNS)-A and licensed practical nurse (LPN)-C stated staff were expected to perform hand hygiene after performing personal cares and when removing gloves, before touching other items.<br><br>The licensee's Gloves policy, revised April 6, 2020, indicated gloves were to be worn whenever there may be direct contact between any employee and resident or other staff bodily fluids, contaminated objects, meal prep, serving meal plates and dining table cleaning. The procedure included washing hands, applying gloves to both hands, completing the cares, discarding contaminated materials in proper receptacle, removing gloves, disposing of gloves, and rewashing hands per hand washing policy.<br><br>The licensee's Hand Washing policy, revised April 1, 2020, indicated proper hand washing | 0 510 | | |

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| 0 510 | Continued From page 10<br><br>techniques should be used to protect against the spread of infection, and directed hand washing shall be completed:<br>- immediately before touching a resident;<br>- before touching a resident's immediate environment;<br>- after contact with blood, body fluids, or contaminated surfaces;<br>- immediately after glove use;<br>- before, during, and after preparing food;<br>- before eating food;<br>- before and after caring for someone who is sick;<br>- before and after treating a cut or wound;<br>- after using the toilet;<br>- after changing incontinent products or cleaning up after someone who has used the toilet;<br>- after blowing your nose, coughing, or sneezing; and<br>- after touching garbage.<br>Also included, "When conducting a procedure requiring the use of gloves, proper hand washing shall be completed before donning gloves and after removing gloves.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for | 0 550 | | |

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| 0 550 | Continued From page 11<br><br>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. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, information about the facility's grievance procedure with the required content. This had the potential to affect the licensee's current residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>During the initial tour on November 12, 2024, at 11:24 a.m., with owner (O)-B, the surveyor observed the main entry area of the facility where there was a table with a visitor sign-in form and various postings. The surveyor observed a small sign taped to the wall above the table, which indicated the name, telephone number, and email contact information of the individual who was | 0 550 | | |

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| 0 550 | Continued From page 12<br><br>responsible for handling resident grievances. Another posted document included contact information for the Office of Ombudsman for Long Term Care (OOLTC) and the Office of Ombudsman for Mental Health and Developmental Disabilities (OOMHDD); however, the postings lacked the contact information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC), as required.<br><br>On November 12, 2024, at 12:02 p.m., clinical nurse supervisor (CNS)-A and community coordinator (CC)-M stated the MAARC contact information was posted in the "green room," and directed the surveyor to a bulletin board in a room near the front entrance, and displayed a document behind other documents, posted in a plastic sleeve, with the MAARC contact information. CNS-A and CC-M stated the "green room" was used by staff as a work room, and visitors did not access this room unless accompanied by staff. CNS-A and CC-M stated the MAARC contact information was not posted in a conspicuous place, as required.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 550 | | |
| 0 640 SS=F | 144G.42 Subd. 7 Posting information for reporting suspected c<br><br>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 | 0 640 | | |

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| 0 640 | Continued From page 13<br><br>common areas and near telephones provided by the assisted living facility;<br>(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<br>(3) providing reasonable accommodations with information and notices in plain language.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to support protection and safety by not posting the 911 emergency number in common areas and near telephones provided by the facility, as required. This had the potential to affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>During the initial tour on November 12, 2024, at 11:24 a.m., with owner (O)-B, the surveyor observed the main entry area of the facility where there was a table with a visitor sign-in form and various postings, and in common areas throughout the facility. The surveyor did not observe the 911 emergency number posted.<br><br>On November 12, 2024, at 12:02 p.m., clinical nurse supervisor (CNS)-A and community | 0 640 | | |

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| 0 640 | Continued From page 14<br><br>coordinator stated the 911 emergency number was not posted as required, and stated they would post this right away.<br><br>The licensee's Abuse Prevention and Reporting Plan policy, effective July 28, 2021, included, "In the case of immediate danger call 911;" however, the policy did not direct posting the 911 emergency number in common areas and near telephones provided by the facility, as required.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 640 | | |
| 0 730 SS=F | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous | 0 730 | | |

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| 0 730 | Continued From page 15<br><br>assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(11) documentation that services have been provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure resident records included a discharge summary with the required content for one of one discharged resident (R4).<br><br>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 | 0 730 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

| (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 |
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| 0 730 | Continued From page 16<br><br>failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>R4's diagnoses included bacteremia (bacteria in the blood stream) and stroke.<br><br>R4 began receiving services on June 26, 2024, and was discharged on September 16, 2024.<br><br>R4's progress notes, dated September 16, 2024, indicated R4 was discharged to another facility, per resident and family, and included, "Refer to cumulative diagnosis sheet for diagnosis, nursing notes, medication lists and service plan agreements for course of stay." Also included, current supply of medications were sent with resident's family member and resident at discharge.<br><br>R4's record included a Discharge Summary, dated September 16, 2024, which indicated R4's admission and discharge date, the services received indicated "See service plan agreements for services received including medication management and housing with services," the reason for initiation of services noted family and resident request, summary of services provided during course of services indicated "See service plan agreements," reason for discharge noted resident moved to another assisted living facility, and condition upon discharge indicated, "Stable." Also included, the attending physician was notified of summary available and noted medications were sent with family upon discharge. There was no evidence that the discharge summary was provided to the resident, and with the resident's consent, the resident's representatives and case manager. The | 0 730 | | |

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| 0 730 | Continued From page 17<br><br>discharge summary lacked the following:<br>- a summary of the resident's stay that included diagnoses, course of illnesses, allergies, treatment and therapies, and pertinent lab, radiology, and consultation results; and<br>- a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status.<br><br>On November 13, 2024, at 10:39 a.m., clinical nurse supervisor (CNS)-A stated she wasn't aware that the licensee's discharge summary was lacking the required content. CNS-A stated the form was generated from the electronic record and was the same for all residents being discharged.<br><br>The licensee's Discharge Summary Policy, dated July 28, 2021, indicated upon discharge, a discharge summary would be created by the licensed personnel and would include, but not be limited to, the following:<br>- reason for the initiation of services;<br>- reason for the discontinuation of services; and<br>- resident's condition at discontinuation of services.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days | 0 730 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with | 0 780 | | |

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| 0 780 | Continued From page 18<br><br>the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and<br>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code provisions. These deficient conditions had the ability to affect all staff and residents.<br><br>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). | 0 780 | | |

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| 0 780 | Continued From page 19<br><br>The findings include:<br><br>On November 14, 2024, at 11:40 a.m., surveyor toured the facility with owner (O)-B. Surveyor observed several fire-resistant rated doors throughout the facility including resident rooms 101, 102, 105, 106, 107, 108, 110 (memory care) 201, 205, 206, 207, 208, 210, 212, 213, 214, 215, 218, 219, 220, 222, 223, and 224 with kick down door hold open devises that prevented the doors from closing automatically.<br><br>Fire resistant rated doors are required to automatically close and latch to prevent the spread of flame and smoke in the event of a fire or similar emergency in accordance with MNSFC Section 1105.<br><br>These deficient conditions were visually verified by O-B accompanying on the tour.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 780 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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. | 0 800 | | |

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| 0 800 | Continued From page 20<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors.<br><br>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).<br><br>The findings include:<br><br>On November 13, 2024, at 2:10 p.m., surveyor toured the facility with owner (O)-B. The following maintenance issues were observed.<br><br>First floor spa bathroom on the east wing had a hole in the ceiling above the tub. Spa bathroom in memory care had a missing vent cover and black stains around the vent opening.<br><br>Mechanical room (DC) furnace had black stains on the ceiling around the duct.<br><br>O-B stated they understood the above-listed deficiencies.<br><br>TIME PERIOD FOR CORRECTION: twenty-one | 0 800 | | |

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| 0 800 | Continued From page 21<br>(21) days. | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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. | 0 810 | | |

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| 0 810 | Continued From page 22<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On November 13, 2024, at 11:47 a.m., owner (O)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN:<br><br>The FSEP (fire safety and evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) was very basic. The provided FSEP was from a third-party provider and had not been updated to meet the specific layout of this facility and provide complete actions for employees to take in the event of a fire or similar emergency. | 0 810 | | |

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| 0 810 | Continued From page 23<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 0 970 SS=C | 144G.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for personal property of a resident. This had the potential to affect all current residents.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>The Assisted Living Housing with Services Contract, reviewed April 17, 2024, included the | 0 970 | | |

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| 0 970 | Continued From page 24<br><br>following clause which indicated the resident would waive the licensee's liability for personal property of the resident:<br>-On the second page of the contract, identified as "Page 1 of 3," "[Licensee] is not responsible for any lost or stolen property belonging to Resident or any motor vehicle belonging to Resident while they are in use or parked on [licensee's] property. We recommend that you do not keep items of great value in apartment as a precaution. We do offer the option of a petty cash fund for those who would benefit from having access to personal spending money."<br><br>On November 14, 2024, at 2:40 p.m., licensed assisted living director (LALD)-A stated he was aware the contract must not contain language waiving the licensee's liability for the personal property of a resident and thought that statement had been removed.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 970 | | |
| 01060 SS=F | 144G.52 Subd. 9 Emergency relocation<br><br>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the | 01060 | | |

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| 01060 | Continued From page 25<br><br>location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;<br>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and<br>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.<br>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for one of one resident (R1) whom was hospitalized.<br><br>This practice resulted in a level two violation (a | 01060 | | |

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| 01060 | Continued From page 26<br><br>violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>R1's diagnoses included Parkinson's disease, type II diabetes, and anxiety.<br><br>R1's Service Plan Agreement, dated September 16, 2022, indicated R1 received services including bathing assistance, dressing, grooming, monitoring supplies, managing appointments, assistance with wheeling needs, socialization, dining reminders, compression stockings, reminders for meals, medication administration, housekeeping and laundry.<br><br>R1's Progress Notes included:<br>- September 25, 2024, R1 had a fall in her apartment, witnessed by family. R1 was self ambulating with the walker and fell, hitting the back of her head. R1 refused medical attention. Fall paperwork and vital/neuro sheet were started per facility policy/procedure. R1 changed her mind and decided to go to the emergency room and complained of right leg pain. R1 was transported to the hospital;<br>- September 26, 2024, R1 was transferred to a different hospital with a spinal fracture and small subdural hematoma (brain bleed);<br>- October 2, 2024, R1 would be transferred to a Transitional Care Unit; and<br>- November 5, 202, R1 returned to the facility.<br><br>R1's record lacked evidence of a written notice | 01060 | | |

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| 01060 | Continued From page 27<br><br>provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum:<br>- the reason for the relocation;<br>- the name and contact information for the location to which the resident had been relocated and any new service provider;<br>- contact information for the Office of Ombudsman for Long-Term Care (OOLTC);<br>- if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and<br>- a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal.<br>In addition, the licensee failed to provide the written notice to the Office of Ombudsman for Long-Term Care when R1 was relocated and had not returned to the facility within four days.<br><br>On November 13, 2024, at 10:39 a.m., clinical nurse supervisor (CNS)-A stated they were not aware of the above requirement and the licensee was not currently providing a notice when residents were hospitalized. In addition, CNS-A stated they were not aware the Office of Ombudsman for Long-Term Care needed to be notified if the resident was relocated and had not returned to the facility within four days.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01060 | | |

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| 01290 | Continued From page 28 | 01290 | | |
| 01290 SS=I | 144G.60 Subdivision 1 Background studies required<br><br>(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.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure background studies were conducted prior to staff providing services, for one of one employee (unlicensed personnel (ULP)-E). In addition, the licensee failed to ensure two of two employees (food service manager (FSM)-F, cook (C)-G) had a fully compliant background study by December 31, 2022, after having an emergency background study issued in response to the COVID-19 pandemic.<br><br>This practice resulted in a level three violation (a violation that harmed a client's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that | 01290 | | |

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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

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| 01290 | Continued From page 29<br><br>has affected or has potential to affect a large portion or all of the clients).<br><br>This resulted in an immediate order for correction issued on November 13, 2024.<br><br>The findings include:<br><br>On November 12, 2024, at 12:45 p.m., the surveyor reviewed the licensee's NETStudy 2 (web-based system to ensure eligibility of staff performing services) roster, of the current employees, printed November 12, 2024, by payroll manager (PM)-H. When comparing the employee list provided upon entrance to the NETStudy 2 roster, ULP-E was listed on the employee list; however, was not listed on the NETStudy 2 roster. Also noted, FSM-F was listed on the NETStudy 2 roster as "Disqualified - Set Aside - COVID-19 Study - Expired," with an expiration date of December 31, 2022. In addition, C-G was listed on the NETStudy 2 roster as "Eligible - COVID-19 Study - Expired," with an expiration date of December 31, 2022.<br><br>ULP-E had a hire date of May 2, 2024. ULP-E's record lacked a background clearance letter.<br><br>FMS-F had a hire date of May 27, 2003, and had a Background Study Clearance letter, dated June 4, 2003, and a letter from the Minnesota Department of Health, dated February 8, 2022, which indicated the result of a review of a disqualification due to an incident that occurred on April 11, 2017, was "set aside," and although FMS-F continued to have a disqualification, the licensee could allow him/her to provide services.<br><br>C-G had a hire date of September 16, 2009, and had a Background Study Clearance letter, dated | 01290 | | |

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| 01290 | Continued From page 30<br>July 6, 2021.<br><br>On November 12, 2024, at 3:14 p.m., PM-H stated she did not know how ULP-E's background study was missed, although assumed ULP-E did not complete the finger print portion on the study. PM-H stated she did not receive any notification of this. PM-H stated she was aware that staff should not work with residents until a background clearance was received, but thought they had received one for ULP-E. PM-H stated ULP-E worked today, worked independently while providing services to the residents, and stated they would need to get this taken care of immediately. PM-H stated FSM-F worked part-time and had a disqualification that was "set aside" in February 2022, when a background study was completed prior to the assisted living licensure on August 1, 2021, but she did not realize that another background study was needed due to the study being an emergency background study completed during the pandemic. PM-H stated C-G worked part-time and she attempted to do a background study for C-G, but it was difficult due to him not having an email. PM-H stated she assumed he did not follow through with the finger printing portion of the study. PM-H stated FSM-F and C-G worked in the kitchen; however, stated each had access to the licensee's residents.<br><br>The licensee's Background Checks policy, revised April 16, 2014, indicated all employees of the licensee who will have independent, unsupervised contact with residents shall complete a Minnesota Department of Human Services Background Study. The policy also included, no employee may have independent direct contact with any resident until acceptable result of the background study has been | 01290 | | |

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| 01290 | Continued From page 31<br>received.<br>No further information was provided.<br>TIME PERIOD FOR CORRECTION: IMMEDIATE | 01290 | | |
| 01470 SS=D | 144G.63 Subd. 2 Content of required orientation<br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;<br>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and<br>(9) a review of the types of assisted living | 01470 | | |

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| 01470 | Continued From page 32<br><br>services the employee will be providing and the facility's category of licensure.<br>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of one employee (unlicensed personnel (ULP)-L).<br><br>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 | 01470 | | |

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| 01470 | Continued From page 33<br><br>a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>ULP-L was hired on June 24, 2024, to provide direct assisted living services to residents.<br><br>ULP-L's employee record included an Orientation Checklist, dated June 24, 2024, which included review of the licensee's policies and procedures, emergency response procedures,<br>copy of the resident's Bill of Rights, and complaint procedure. ULP-L's employee record also included Relias (online education for healthcare organizations) transcript, dated November 29, 2023, through May 27, 2024, identified as transcript from previous SNF (skilled nursing facility) employment, which indicated courses completed included Abuse, Neglect, and Exploitation and Minnesota SNF (skilled nurse facility) Vulnerable Adult Policy review.<br><br>ULP-L's employee record lacked evidence of orientation to assisted living regulations (Minnesota Statutes, chapter 144G.63, subdivision 2) effective August 1, 2021, for the following:<br>- an overview of this assisted living statutes;<br>- reporting maltreatment of vulnerable adults or minors;<br>- consumer advocacy services;<br>- a review of the types of assisted living services the employee will be providing and the licensee's category of licensure; and<br>- principles of person-centered planning/service delivery.<br><br>On November 14, 2024, at 10:50 a.m., licensed assisted living director (LALD)-D stated ULP-L | 01470 | | |

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| 01470 | Continued From page 34<br><br>worked at a skilled nursing facility prior to being hired by the licensee, and they were able to use her prior training for some portions of the orientation; however, LALD-D stated some contents of the training may have been missed.<br><br>The licensee's Orientation for Home Care Staff (sic) policy, dated June 3, 2014, indicated, "All Home Care employees must complete the orientation to home care requirements before providing home care services to clients. The licensee's policy did not address the requirements of current assisted living licensure.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01470 | | |
| 01500 SS=F | 144G.63 Subd. 5 Required annual training<br><br>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:<br>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;<br>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such | 01500 | | |

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| 01500 | Continued From page 35<br><br>as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;<br>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;<br>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.<br>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;<br>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.<br><br>This MN Requirement is not met as evidenced by: | 01500 | | |

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| 01500 | Continued From page 36<br><br>Based on interview and record review, the licensee failed to ensure annual training including all required topics for each twelve months of employment for three of three employees (clinical nurse supervisor (CNS)-A, licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-K).<br><br>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).<br><br>The findings include:<br><br>CNS-A began her employment with the licensee on April 6, 2020.<br><br>LPN-C began her employment with the licensee on May 24, 2012.<br><br>ULP-K began her employment with the licensee on July 22, 2012.<br><br>CNS-A, LPN-C, and ULP-K's employee records lacked the following required annual training content:<br>- review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures.<br><br>On November 14, 2024, at 1:50 p.m., CNS-A stated she was not sure how this was documented in employee records when completing annual training, and stated there was | 01500 | | |

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| 01500 | Continued From page 37<br><br>a form used in past years that the employee would sign to document review of policies and procedures, but was not found in the above records.<br><br>The licensee's Required Annual Staff Training, dated June 5, 2014, indicated all staff that performed direct home care services would complete a minimum of 8 hours of annual training for each 12 months of employment, and must include a review of the home care provider's (sic) policies and procedures relating to the provision of home care services (sic) and how to implement those policies and procedures.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01500 | | |
| 01620 SS=D | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(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.<br>(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 | 01620 | | |

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| 01620 | Continued From page 38<br><br>calendar days from the date of the last review.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment after a change of condition for one of one resident (R1).<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on November 12, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated comprehensive assessments were completed upon admission, within 14 days, every 90 days, and with changes in condition.<br><br>On November 13, 2024, at 7:45 a.m., the surveyor observed as unlicensed personnel (ULP)-K checked R1's blood sugar and administered R1's oral medications. R1 was seated in the wheelchair, had a large brace | 01620 | | |

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| 01620 | Continued From page 39<br><br>around her torso, had blue foam boots on each foot, and both feet were elevated on pillows.<br><br>R1's diagnoses included Parkinson's disease, type II diabetes, and anxiety.<br><br>R1's Service Plan Agreement, dated August 22, 2024, indicated R1 received services including range of motion exercises, compression garment, managing appointments, monitoring supplies, assistance with wheeling, socialization, activities, bathing assistance, grooming, dining reminders and escort, dressing, compression stockings, physical assist of one with ambulation and transfers as needed, toileting assistance, medication administration, blood sugar checks once daily, skin monitoring, housekeeping and laundry.<br><br>R1's Master Assessment, dated August 26, 2024, identified as 90 day assessment, indicated R1 was able to communicate and make her needs known, needed physical assistance to pull on and clean compression stockings, was independent for dental care, had no hearing impairment, was independent with vision aids, needed assistance of one staff for escort to dining room, dressing, grooming, toileting, bathing, and transferring, was independent with positioning, needed stand by assist with ambulating, assistance of one with wheeling, and needed assistance with housekeeping and laundry.<br><br>R1's Progress Notes included:<br>- September 25, 2024, R1 had a fall in her apartment, witnessed by family. R1 was self ambulating with the walker and fell, hitting the back of her head. R1 refused medical attention. Fall paperwork and vital/neuro sheet were started per facility policy/procedure. R1 changed her | 01620 | | |

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| 01620 | Continued From page 40<br><br>mind and decided to go to the emergency room and complained of right leg pain. R1 was transported to the hospital;<br>- September 26, 2024, R1 was transferred to a different hospital with a spinal fracture and small subdural hematoma (brain bleed);<br>- October 2, 2024, R1 would be transferred to a Transitional Care Unit; and<br>- November 5, 202, R1 returned to the facility with the following care plan changes:<br>- back brace on at all times applied over clothing when out of bed, off when in bed;<br>- blue boots to both feet at all times except when transferring, ambulating, and during dressing/bathing cares;<br>- monitor skin condition both heels and tips of toes and lower left extremity for redness or pain;<br>- blood sugar checks three times daily;<br>- physical assist of two with bed mobility;<br>- float heels in bed with blue boots on;<br>- discontinue compression stockings;<br>- turn every two hours; and<br>- physical assistance with dressing, grooming, denture care, and toileting.<br><br>R1's Modifications to the Service Plan Agreement, dated November 5 2024, indicated R1 received modified or additional services including brace on at all times except when in bed, boots to both feet, skin condition monitoring of heels/toes/lower left extremity, blood sugar checks three times daily, assistance with bed mobility, floating heels while in bed, turn every two hours, ice pack to right shoulder three times daily, physical assistance with hearing aid and denture care.<br><br>R1's record lacked a change of condition reassessment after R1 sustained a fall with injury and required hospitalization and rehabilitation, | 01620 | | |

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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

| (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 |
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| 01620 | Continued From page 41<br><br>and changes to the plan of care upon return to the facility.<br><br>On November 14, 2024, at 8:59 a.m., CNS-A stated there was no ongoing resident reassessment completed for R1 when the needs of the resident changed, and there should have been.<br><br>The licensee's Service Plans policy, dated July 28, 2021, indicated, an individualized initial assessment must be conducted in-person by a registered nurse, when assisted living services are being provided. The policy incorrectly noted the initial assessment must be completed within five day after initiation of assisted living services. The policy also directed resident monitoring and reassessment must be conducted no more than 14 days after initiation of services, and ongoing resident monitoring and reassessment must be conducted, as needed, based on changes in the needs of the resident and cannot exceed 90 days from the last date of the assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01690 SS=F | 144G.71 Subdivision 1 Medication management services<br><br>(a) This section applies only to assisted living facilities that provide medication management services.<br>(b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and | 01690 | | |

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| 01690 | Continued From page 42<br><br>procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines.<br>(c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures under the supervision and direction of a registered nurse (RN).<br><br>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 | 01690 | | |

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| 01690 | Continued From page 43<br><br>are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>During the entrance conference on November 12, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents.<br><br>The licensee's provided policies lacked:<br>- monitoring and evaluating medication use; and<br>- educating residents and legal and designated representatives about medications.<br><br>On November 14, 2024, at 12:25 p.m., licensed assisted living director (LALD)-D stated she had provided all of the medication policies.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01690 | | |
| 01700 SS=F | 144G.71 Subd. 2 Provision of medication management services<br><br>(a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the | 01700 | | |

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| 01700 | Continued From page 44<br><br>resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.<br>(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the required content for one of one resident (R1).<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on November 12, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. | 01700 | | |

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| 01700 | Continued From page 45<br><br>On November 13, 2024, at 7:45 a.m., the surveyor observed as unlicensed personnel (ULP)-K checked R1's blood sugar and administered R1's oral medications.<br><br>R1's diagnoses included Parkinson's disease, type II diabetes, and anxiety.<br><br>R1's Service Plan Agreement, dated August 22, 2024, indicated R1 received services including range of motion exercises, compression garment, managing appointments, monitoring supplies, assistance with wheeling, socialization, activities, bathing assistance, grooming, dining reminders and escort, dressing, compression stockings, physical assist of one with ambulation and transfers as needed, toileting assistance, medication administration, blood sugar checks once daily, skin monitoring, housekeeping and laundry.<br><br>R1's Master Assessment, dated August 26, 2024, identified as 90 day assessment, indicated under Medication Assistance, R1 used the house pharmacy, and under Medication Management, R1 utilized the central storage of medications due to request and/or diagnosis.<br><br>R1's prescriber orders included a mild pain reliever, medication to prevent heart attack or stroke, two supplements, medication used to treat symptoms of Parkinson's disease, medication to decrease fluid excess, sleep aid, medication to treat diabetes, treat high blood pressure, treat constipation, and treat high cholesterol.<br><br>R1's Medication Administration Record (MAR), dated November 1, 2024, through November 13, 2024, listed medications as prescribed, times to | 01700 | | |

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| 01700 | Continued From page 46<br><br>be administered, and staff initials on each date to indicate the medications had been given.<br><br>R1's record lacked evidence the RN had conducted a medication assessment to include:<br>- identification and review of all medications the resident is known to be taking;<br>- must be conducted face to face;<br>- indications for medications;<br>- side effects;<br>- contraindications;<br>- allergic or adverse reactions, and actions to address these issues; and<br>- identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications.<br><br>On November 14, 2024, at 1:36 p.m., CNS-A stated the medication management assessment was the same for all residents and was included in the Master Assessment in the electronic medical record, and stated they answered the questions that the system presented. CNS-A stated she was not aware of the required content of the medication management assessment and would be working with the software company to add the appropriate questions so that staff would complete the assessment with the required content.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01700 | | |

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| 01710 | Continued From page 47 | 01710 | | |
| 01710 SS=F | 144G.71 Subd. 3 Individualized medication monitoring and reas<br><br>The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for three of three residents (R1, R2, R3) who received medication management services.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on November 12, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents.<br><br>R1<br>On November 13, 2024, at 7:45 a.m., the surveyor observed as unlicensed personnel | 01710 | | |

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| 01710 | Continued From page 48<br><br>(ULP)-K checked R1's blood sugar and administer R1's oral medications.<br><br>R1's diagnoses included Parkinson's disease, type II diabetes, and anxiety.<br><br>R1's Service Plan Agreement, dated August 22, 2024, indicated R1 received services including medication management and administration.<br><br>R1's Master Assessment, dated August 26, 2024, identified as 90 day assessment, indicated under Medication Assistance, R1 used the house pharmacy, and under Medication Management, R1 utilized the central storage of medications due to request and/or diagnosis.<br><br>R1's prescriber orders, printed on November 13, 2024, included a mild pain reliever, medication to prevent heart attack or stroke, two supplements, medication used to treat symptoms of Parkinson's disease, medication to decrease fluid excess, sleep aid, medication to treat diabetes, treat high blood pressure, treat constipation, and treat high cholesterol.<br><br>R1's Medication Administration Record (MAR), dated November 1, 2024, through November 13, 2024, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given.<br><br>R1's record included a MN (Minnesota) Medication Treatment Therapy Management Plan, dated September 20, 2022.<br><br>R1's record did not include an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking, including a | 01710 | | |

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| 01710 | Continued From page 49<br><br>review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion.<br><br>R2<br>R2's diagnoses included Parkinson's disease, anxiety disorder, and dementia with mood disturbance.<br><br>R2's Service Plan Agreement, dated August 10, 2023, indicated R2 received services including medication management and administration.<br><br>R2's Master Assessment, dated August 16, 2024, identified as 90 day assessment, indicated under Medication Assistance, R2 used the house pharmacy, and under Medication Management, R2 utilized the central storage of medications due to request and/or diagnosis.<br><br>R2's prescriber orders, printed on November 13, 2024, included an antianxiety, two medications to treat symptoms of Parkinson's disease, medication to treat high blood pressure, mild pain reliever, medication to treat low thyroid hormone, medication to reduce stomach acid, an antidepressant, an antipsychotic, and a supplement.<br><br>R2's MAR, dated November 1, 2024, through November 12, 2024, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given.<br><br>R2's record included a MN Medication Treatment Therapy Management Plan, dated August 8, 2023. | 01710 | | |

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| 01710 | Continued From page 50<br><br>R2's record did not include an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking, including a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion.<br><br>R3<br>R3's diagnoses included multiple sclerosis (an autoimmune disease that affects the brain and spinal cord), chronic fatigue, and mild cognitive impairment.<br><br>R3's Service Plan Agreement, dated July 9, 2024, indicated R3 received services including medication management and administration.<br><br>R3's Master Assessment, dated October 8, 2024, identified as 90 day assessment, indicated under Medication Assistance, R3 used the house pharmacy, and under Medication Management, R3 utilized the central storage of medications due to request and/or diagnosis.<br><br>R3's prescriber orders, dated January 8, 2024, included a medication to treat muscle spasms, medication to decrease fluid excess, mild pain reliever, medication to treat low thyroid hormone, medication to treat pain from nerve damage, a stool softener, and a supplement.<br><br>R3's MAR, dated November 1, 2024, through November 13, 2024, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given.<br><br>R3's record included a MN Medication Treatment | 01710 | | |

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| 01710 | Continued From page 51<br><br>Therapy Management Plan, dated February 11, 2022.<br><br>R3's record did not include an annual face-to-face medication reassessment to include an identification and review of all medications the resident was known to be taking including, a review of the indications for use, side effects, contraindications, allergic or adverse reactions, and interventions needed in management of medications to prevent diversion.<br><br>On November 14, 2024, at 1:36 p.m., CNS-A stated the medication management assessment was the same for all residents and was included in the Master Assessment in the electronic medical record, and stated they answered the questions that the system presented. CNS-A stated she was not aware of the required content of the medication management assessment or that reassessment should be completed as needed, and at a minimum, annually, and would be working with the software company to ensure the questions included all of the required content.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01710 | | |
| 01730 SS=F | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current | 01730 | | |

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| 01730 | Continued From page 52<br><br>individualized medication management record for each resident based on the resident's assessment that must contain the following:<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to develop an individualized medication management plan prior | 01730 | | |

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| 01730 | Continued From page 53<br><br>to providing medication management services, and with the required content, for three of three residents (R1, R2, R3).<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on November 12, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents.<br><br>R1<br>On November 13, 2024, at 7:45 a.m., the surveyor observed as unlicensed personnel (ULP)-K checked R1's blood sugar and administered R1's oral medications.<br><br>R1's diagnoses included Parkinson's disease, type II diabetes, and anxiety.<br><br>R1's Service Plan Agreement, dated August 22, 2024, indicated R1 received services including medication management and administration.<br><br>R1's Master Assessment, dated August 26, 2024, identified as 90 day assessment, indicated under Medication Assistance, R1 used the house pharmacy, and under Medication Management, R1 utilized the central storage of medications due to request and/or diagnosis. The assessment lacked a medication management assessment. | 01730 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| 01730 | Continued From page 54<br><br>R1's prescriber orders, printed on November 13, 2024, included a mild pain reliever, medication to prevent heart attack or stroke, two supplements, medication used to treat symptoms of Parkinson's disease, medication to decrease fluid excess, sleep aid, medication to treat diabetes, treat high blood pressure, treat constipation, and treat high cholesterol.<br><br>R1's Medication Administration Record (MAR), dated November 1, 2024, through November 13, 2024, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given.<br><br>R1's record included a MN (Minnesota) Medication Treatment Therapy Management Plan, dated September 20, 2022. The plan indicated the licensee would provide administration of medications, medications would be securely stored by the licensee in the locked medication cart and accessed by licensee staff, and community staff would monitor supplies and would coordinate refills. R1's record lacked a current individualized medication management plan, based on the resident's assessment, to include the following required content:<br>- a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>- documentation of specific resident instructions relating to the administration of medications;<br>- identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>- identification of medication management tasks that may be delegated to unlicensed personnel;<br>- procedures for staff notifying a registered nurse | 01730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 01730 | Continued From page 55<br><br>or appropriate licensed health professional when a problem arises with medication management services; and<br>- any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br><br>R2<br>R2's diagnoses included Parkinson's disease, anxiety disorder, and dementia with mood disturbance.<br><br>R2's Service Plan Agreement, dated August 10, 2023, indicated R2 received services including medication management and administration.<br><br>R2's Master Assessment, dated August 16, 2024, identified as 90 day assessment, indicated under Medication Assistance, R2 used the house pharmacy, and under Medication Management, R2 utilized the central storage of medications due to request and/or diagnosis.<br><br>R2's prescriber orders, printed on November 13, 2024, included an antianxiety, two medications to treat symptoms of Parkinson's disease, medication to treat high blood pressure, mild pain reliever, medication to treat low thyroid hormone, medication to reduce stomach acid, an antidepressant, an antipsychotic, and a supplement.<br><br>R2's MAR, dated November 1, 2024, through November 12, 2024, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given. | 01730 | | |

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| 01730 | Continued From page 56<br><br>R2's record included a MN Medication Treatment Therapy Management Plan, dated August 8, 2023. The plan indicated the licensee would provide administration of medications, medications would be securely stored by the licensee in the locked medication cart and accessed by licensee staff, and community staff would monitor supplies and would coordinate refills. R2's record lacked a current individualized medication management plan, based on the resident's assessment, to include the following required content:<br>- a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>- documentation of specific resident instructions relating to the administration of medications;<br>- identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>- identification of medication management tasks that may be delegated to unlicensed personnel;<br>- procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>- any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br><br>R3<br>R3's diagnoses included multiple sclerosis (an autoimmune disease that affects the brain and spinal cord), chronic fatigue, and mild cognitive impairment. | 01730 | | |

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| 01730 | Continued From page 57<br><br>R3's Service Plan Agreement, dated July 9, 2024, indicated R3 received services including medication management and administration.<br><br>R3's Master Assessment, dated October 8, 2024, identified as 90 day assessment, indicated under Medication Assistance, R3 used the house pharmacy, and under Medication Management, R3 utilized the central storage of medications due to request and/or diagnosis.<br><br>R3's prescriber orders, dated January 8, 2024, included a medication to treat muscle spasms, medication to decrease fluid excess, mild pain reliever, medication to treat low thyroid hormone, medication to treat pain from nerve damage, a stool softener, and a supplement.<br><br>R3's MAR, dated November 1, 2024, through November 13, 2024, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given.<br><br>R3's record included a MN Medication Treatment Therapy Management Plan, dated February 11, 2022. The plan indicated the licensee would provide administration of medications, medications would be securely stored by the licensee in the locked medication cart and accessed by licensee staff, and community staff would monitor supplies and would coordinate refills. R3's record lacked a current individualized medication management plan, based on the resident's assessment, to include the following required content:<br>- a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's | 01730 | | |

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| 01730 | Continued From page 58<br><br>directions;<br>- documentation of specific resident instructions relating to the administration of medications;<br>- identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>- identification of medication management tasks that may be delegated to unlicensed personnel;<br>- procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>- any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br><br>On November 14, 2024, at 1:36 p.m., CNS-A stated the medication management assessment was the same for all residents and was included in the Master Assessment in the electronic medical record, and stated they answered the questions that the system presented. CNS-A stated she was not aware of the required content of the medication management assessment or that reassessment should be completed as needed, and at a minimum, annually, and would be working with the software company to ensure the questions included all of the required content. CNS-A stated the individualized medication management plan could not be completed accurately without conducting a medication management assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |

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| 01760 SS=E | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed for one of three residents (R1). In addition, the licensee failed to ensure insulin was administered per the manufacturer's instructions for one of one resident (R7).<br><br>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 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).<br><br>The findings include: | 01760 | | |

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| 01760 | Continued From page 60<br><br>MEDICATIONS AS PRESCRIBED<br>R1's diagnoses included Parkinson's disease, type II diabetes, and anxiety.<br><br>R1's Service Plan Agreement, dated August 22, 2024, indicated R1 received services including range of motion exercises, compression garment, managing appointments, monitoring supplies, assistance with wheeling, socialization, activities, bathing assistance, grooming, dining reminders and escort, dressing, compression stockings, physical assist of one with ambulation and transfers as needed, toileting assistance, medication administration, blood sugar checks once daily, skin monitoring, housekeeping and laundry.<br><br>On November 13, 2024, at 7:37 a.m., the surveyor observed while unlicensed personnel (ULP)-K checked R1's blood sugar, administered eye drops, and provided oral medications which included:<br>- furosemide 20 mg (milligrams) one tablet by mouth daily, scheduled at 7:00 a.m.; and<br>- furosemide 40 mg one tab by mouth daily, scheduled at 8:00 a.m.<br>When questioned about the two different doses of furosemide, ULP-K showed the surveyor the medications listed on the electronic device she was using, to be administered as noted above. ULP-K pulled the two punch packs from the pile and showed the surveyor each medication and the directions, as listed above.<br><br>R1 was hospitalized after a fall on September 25, 2024, followed by a rehabilitation stay, and returned to the facility on November 5, 2024.<br><br>R1's prescriber orders, dated November 7, 2024, | 01760 | | |

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| 01760 | Continued From page 61<br><br>included Furosemide (treat fluid excess) 20 mg (milligrams) one tablet daily. On November 8, 2024, an electronic order was received from R1's provider for "Furosemide, 20 mg tab, give 12 tabs by mouth once daily." On November 9, 2024, an electronic order was received from R1's provider, which indicated, "DC [discontinue] previous order for furosemide continue furosemide 20 mg 1 tab qd [every day]."<br><br>R1's Progress Notes, dated November 10, 2024, at 8:20 a.m., documented by resident coordinator (RC)-N, indicated order from November 8, 2024, was received and sent to pharmacy, and noted the pharmacist would clarify the order. On November 11, 2024, at 8:43 a.m., RC-N noted clarification order was received to DC previous order for furosemide continue furosemide 20 mg one tab daily.<br><br>On November 11, 2024, at 11:07 a.m., an electronic order was received from R1's provider, which indicated, "order clarification 1. Furosemide, 20 mg tab, give 2 tabs by mouth once daily."<br><br>R1's Progress Notes, dated November 11, 2024, at 11:23 a.m., RC-N noted, "clarification order - start Furosemide 20 mg give 2 tabs by mouth once daily."<br><br>During an interview on November 14, 2024, at 10:20 a.m., when questioned about the surveyor's observation of R1's medication administration with the two doses of furosemide that were given, licensed practical nurse (LPN)-C stated she would look into this. At 11:05 a.m., LPN-C stated they found that the previous order for furosemide was not discontinued and R1 did indeed receive both doses of furosemide on November 12, 2024, | 01760 | | |

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| 01760 | Continued From page 62<br><br>and November 13, 2024. LPN-C stated the transcription error had been corrected.<br><br>INSULIN ADMINISTRATION<br>R7's diagnoses included type II diabetes.<br><br>R7's Service Plan, printed November 13, 2024, indicated R7 required blood glucose monitoring twice daily and as needed, and insulin administration four times daily by unlicensed personnel.<br><br>R7's prescriber orders, dated October 11, 2024, included blood sugar checks twice daily and as needed, and NovoLog (short acting insulin) Flexpen 12 units subcutaneously (under the skin) three times daily with meals.<br><br>On November 13, 2024, at 7:37 a.m., the surveyor observed unlicensed personnel (ULP)-K prepare to administer R7's insulin. With gloves on, ULP-K placed a needle on the insulin pen without cleaning the rubber plunger, and without priming the pen, ULP-K dialed the insulin pen to 12 units, pulled up R7's shirt to expose her abdomen, and gave the insulin injection into her abdomen. When interviewed, ULP-K stated she usually only primed the needle when opening a new pen, and stated the needles the licensee used could only be used once and showed the surveyor the box that indicated, "For single use only," and explained if she dialed the pen and pushed out the amount of insulin to prime the pen, she would not be able to dial the pen again.<br><br>On November 13, 2024, at 8:18 a.m., clinical nurse supervisor (CNS)-A and LPN-C stated the needle should always be primed when administering insulin and stated they weren't aware of an issue with priming the needles they | 01760 | | |

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| 01760 | Continued From page 63<br><br>were using, but would check into this. At 12:05 p.m., LPN-C demonstrated successfully priming the needle using the current needles the licensee was using. LPN-C stated she provided reeducation to ULP-K.<br><br>ULP-K's employee record included Insulin Pen Skill Competency Test, signed by ULP-K and a registered nurse on January 4, 2016, indicating ULP-K demonstrated competency with the procedure, including wiping the top of the insulin pen with an alcohol swab, attaching the pen needle, and priming the pen with 2 units of insulin.<br><br>On November 14, 2024, at 2:04 p.m., CNS-A stated priming the insulin needle and cleaning the rubber plunger with alcohol prior to putting on the needle was included in the training she provided on insulin administration to staff.<br><br>The manufacturer's instructions for the use of Novolog insulin FlexPens, dated March 2023, directed to clean rubber plunger with alcohol pad prior to attaching needle and for the insulin pen to be primed with two units prior to dialing the prescribed dosage to avoid injecting air and to ensure proper dosing.<br><br>The licensee's Skill Competency for Insulin Pens, dated 2017, included in the procedure to remove the pen cap and clean the tip with sterile alcohol wipe, attach a new needle to the pen, prime the pen and then dial up the correct dose.<br><br>The licensee's Medication & Treatment Orders policy, dated October 29, 2015, indicated the registered nurse was responsible for assuring that current, authorized prescriber orders for medications or treatments administered by staff | 01760 | | |

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| 01760 | Continued From page 64<br><br>were kept on file in the residents' charts and that changes in orders were addressed in the resident's service plan and/or resident's Medication Administration Record and were communicated to the other staff.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |
| 01780 SS=F | 144G.71 Subd. 10 Medication management for residents who will<br><br>(a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that:<br>(1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and implement policies and procedures for giving accurate and current medications for those residents who received medication management services having planned and unplanned times away from home.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 01780 | | |

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| 01780 | Continued From page 65<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on November 12, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents.<br><br>The licensee's Medication Sent for Leave of Absence policy, revised July 29, 2021, lacked the following required content:<br>- for planned time away, the medications must be obtained from the pharmacy or set up by the registered nurse (RN); and<br>- for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days.<br><br>On November 14, 2024, at 12:25 p.m., licensed assisted living director (LALD)-D stated she had provided all of the medication policies.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01780 | | |
| 01790 SS=F | 144G.71 Subd. 10 Medication management for residents who will | 01790 | | |

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| 01790 | Continued From page 66<br><br>(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;<br>(3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and<br>(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled.<br>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:<br>(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and<br>(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:<br>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;<br>(ii) how the container or containers must be labeled;<br>(iii) written information about the medications to be provided;<br>(iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the | 01790 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

| (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 |
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| 01790 | Continued From page 67<br><br>medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;<br>(v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;<br>(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and<br>(vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). | 01790 | | |

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| 01790 | Continued From page 68<br>The findings include:<br><br>During the entrance conference on November 12, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents.<br><br>The licensee's Medication Sent for Leave of Absence policy, revised July 29, 2021, noted the written procedures for the ULP providing medications for residents having unplanned time away when the licensed nurse was not available. The policy lacked the following required content:<br>- how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;<br>- how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative;<br>- a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and<br>- how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication.<br><br>On November 14, 2024, at 12:25 p.m., licensed assisted living director (LALD)-D stated she had provided all of the medication policies. | 01790 | | |

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| 01790 | Continued From page 69<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01790 | | |
| 01920 SS=F | 144G.71 Subd. 23 Loss or spillage<br><br>(a) Assisted living facilities providing medication management must develop and implement procedures for loss or spillage of all controlled substances defined in Minnesota Rules, part 6800.4220. These procedures must require that when a spillage of a controlled substance occurs, a notation must be made in the resident's record explaining the spillage and the actions taken. The notation must be signed by the person responsible for the spillage and include verification that any contaminated substance was disposed of according to state or federal regulations.<br>(b) The procedures must require that the facility providing medication management investigate any known loss or unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop and implement procedures for loss and spillage of all controlled substances defined in Minnesota Rules part 6800.4220.<br><br>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 | 01920 | | |

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| 01920 | Continued From page 70<br>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).<br><br>The findings include:<br><br>During the entrance conference on November 12, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents, including storage of controlled substances.<br><br>On November 14, 2024, at 12:20 p.m., licensed assisted living director (LALD)-D stated the licensee lacked a procedure for loss or spillage of controlled substances, as required.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01920 | | |
| 01930 SS=F | 144G.72 Subd. 2 Policies and procedures<br><br>(a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines.<br>(b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting | 01930 | | |

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| 01930 | Continued From page 71<br><br>treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures that were developed under the supervision and direction of a registered nurse (RN) consistent with current practice standards and guidelines.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on November 12, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided treatment and therapy management services to the licensee's residents.<br><br>The licensee lacked policies and procedures that addressed:<br>- educating and communicating with residents about treatments or therapies they are receiving; and<br>- monitoring and evaluating the treatment or | 01930 | | |

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| 01930 | Continued From page 72<br>therapy.<br><br>On November 14, 2024, at 12:25 p.m., licensed assisted living director (LALD)-D stated she had provided all of the policies and procedures related to treatment and therapy management services.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01930 | | |
| 02070 SS=I | 144G.81 Subd. 4 Awake staff requirement<br><br>An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12).<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in the secured dementia care unit (a secured unit requiring a key code to enter and exit).<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to | 02070 | | |

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| 02070 | Continued From page 73<br><br>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).<br><br>This resulted in an immediate correction order identified on November 13, 2024.<br><br>The findings include:<br><br>The licensee held an Assisted Living with Dementia Care license for forty one (41) residents, with ten (10) of those residents residing on the secured dementia care unit.<br><br>On November 12, 2024, at 10:58 a.m., during the entrance conference, licensed assisted living director (LALD)-D stated the licensee's staffing plan for the overnight shift from 10:15 p.m. until 6:45 a.m., had one unlicensed personnel (ULP) working in the secured dementia care unit and one ULP for the assisted living (AL) section of the facility. LALD-D stated when assistance was needed on the AL section of the facility, such as a two person transfer or a resident fall, it required two staff and would require the ULP from the memory care unit to leave the unit, and assist in the AL section of the facility. LALD-D stated the ULP on the dementia care unit would check all of the residents before leaving the unit, and would go to assist on the AL side. LALD-D stated ULPs were told they could only be gone from the unit for a few minutes. Licensed practical nurse (LPN)-C stated this was the process on the night shift and stated the ULP from the dementia care unit assisted when needed for two person transfers or if a resident had a fall.<br><br>On November 13, 2024, at 6:00 a.m., ULP-I | 02070 | | |

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| 02070 | Continued From page 74<br><br>stated she was assigned to the dementia care unit on the night shift, and stated she and the ULP assigned to the AL section of the facility, helped each other out when needed during the night. ULP-I stated last night, she went up to the second floor to assist the ULP working on the AL side, to change and reposition a resident, and if a resident in the dementia care unit needed a medication during the night, the ULP from the AL side would come and administer the medication. ULP-I stated she keeps the door to the dementia care unit shut when she leaves the unit, because "It's a secured unit." ULP-I stated, "We help each other out. I go over and help when I'm needed."<br><br>On November 13, 2024, at 6:14 a.m., ULP-J stated, "We help each other if needed, whenever it works out for her to come over." ULP-J stated she called ULP-I during the night last night because a resident needed assistance of two staff to reposition in bed. ULP-I stated there were times when she needed help when there was a fall, or a two person assist was needed. ULP-J stated, "If help is needed, we're there for each other."<br><br>On November 13, 2024, at 10:39 a.m., clinical nurse supervisor (CNS)-A stated R1 required assistance of two staff to turn and reposition following hospitalization after a fall that resulted in a vertebral fracture.<br><br>R1 diagnoses included Parkinson's disease, osteoarthritis of bilateral hips, and acute deep vein thrombosis (blood clot) of left lower extremity.<br><br>R1's Modifications to the Service Plan Agreement, dated November 5, 2024, indicated R1 required bed mobility every shift, and turning | 02070 | | |

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| 02070 | Continued From page 75<br><br>schedule every two hours every shift. Also included, "2 [two] staff assist to sit up in bed and get in/out of bed."<br><br>Review of the Staffing Plan, dated November 11, 2024, indicated "Two staff are scheduled for overnight hours."<br><br>Review of the Uniform Disclosure of Assisted Living Services and Amenities, dated January 31, 2024, indicated the number of unlicensed direct staff typically scheduled per shift was "2" for the night shift.<br><br>The licensee's Staff Requirement/Plan Policy, effective April 1, 2021, indicated the licensee must have sufficient staffing 24/7 to meet scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plan. The policy included, "A minimum of two direct-care staff must be scheduled and available to assist at all times whenever a resident requires the assistance of two direct-care staff." The policy did not address staffing requirements in dementia care unit.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate | 02070 | | |
| 02310 SS=F | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(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. | 02310 | | |

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| 02310 | Continued From page 76<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R3) with a hospital bedrail (also called siderail).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On November 13, 2024, at 6:14 a.m., the surveyor entered R3's room with R3's permission. R3 was sitting on the side of the bed, preparing for unlicensed personnel (ULP)-J to transfer her to the bathroom, using a sit-to-stand lift. R3 had a hospital bed with bilateral bedrails in the raised position, affixed to the upper half of the bed frame. The bedrails had six vertical bars and with five open areas and four horizontal bars with six open areas, and were securely attached to the bed frame. R3 stated she used the bedrails to turn from side to side when in bed.<br><br>R3's diagnoses included multiple sclerosis, urinary incontinence, and mild cognitive disorder.<br><br>R3's Service Plan Agreement, signed July 9, 2024, indicated R3 received services including | 02310 | | |

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| 02310 | Continued From page 77<br><br>assistance brushing teeth, bathing, shampooing, dressing, toileting, compression stockings, grooming, assistance with wheeling, supervision with eating, range of motion exercises, physical assistance with activities, orientation, behavior management, bed mobility, and transfers.<br><br>R3's Master Assessment, dated October 8, 2024, indicated R3 had half bedrails, used bedrails for bed mobility, and were not used to restrict the resident's ability to get in or out of bed.<br><br>R3's Risk Assessment for the Use of Bed Rails, last reviewed October 8, 2024, included an assessment of the type of bed and mattress, a discussion of the intended purpose of the bedrail, potential areas of entrapment, whether R3 had agitation or could get out of bed independently, and if R3 and legal representative received bedrail safety information and understood the risks and benefits of bilateral bedrails and consented to the use of the bedrails to assist with repositioning. The risk assessment was updated every 90 days, as required. The risk assessment lacked measurements of the bedrail.<br><br>On November 13, 2024, at 8:18 a.m., clinical nurse supervisor (CNS)-A stated she completed a bedrail assessment every 90 days on the three residents that had bedrails in the facility; however, CNS-A stated the requirements were unreasonable because "we have to measure everything." CNS-A stated measurements were not included in the licensee's assessment.<br><br>The licensee's Siderails policy, dated May 14, 2014, indicated it was the licensee's policy to limit the use of medical devices to those that are considered "safe," based on current standards of practice. The policy indicated the licensee would | 02310 | | |

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| 02310 | Continued From page 78<br><br>assess the use, educate the resident, and when appropriate, the responsible person/Power of Attorney, regarding the risks and benefits of bedrails, and verify that the bedrail in use was of a safe design and utilized consistent with the manufacturer's directions. The policy included a diagram of the entrapment zones identified in the Food and Drug Administration's 2006 recommended dimensional measurements to reduce entrapment.<br><br>The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment with hospital beds, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle.<br><br>The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."<br><br>No further information was provided. | 02310 | | |

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|---|---|---|---|---|
| 02310 | Continued From page 79<br>TIME PERIOD FOR CORRECTION: Two (2) Days | 02310 | | |
| 02320 SS=D | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review the licensee failed to ensure unlicensed personnel ((ULP)-L) followed appropriate transfer procedures for one of one resident (R8).<br><br>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).<br><br>The findings include:<br><br>R2's diagnoses included diabetes and R8 required dementia care.<br><br>While observing medication administration in the dementia care unit on November 13, 2024, at 8:00 a.m., ULP-K asked ULP-L to bring R8 to his | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 26903 | A. BUILDING: _____ B. WING _____ | 11/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

| (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 |
|---|---|---|---|---|
| 02320 | Continued From page 80<br><br>room, from the dining room, so that she could check his blood sugar and administer insulin. R8 was sitting on the seat of a four-wheeled walker at the dining room table. ULP-L walked up to R8 and told him to stay seated and she would bring him to his room. ULP-L grabbed the handles on the four-wheeled walker and pushed R8 backwards down the hallway to his room. Once in the room, ULP-K checked his blood sugar and administered two different insulins, and walked out. R8 self-propelled the four-wheeled walker into the hallway.<br><br>Review of ULP-L's Skill Competency Client Mobility Lifting and Safe Transfers, dated July 16, 2024, indicated ULP-L was deemed competent on transfers from sitting to standing, from wheelchair to bed, from chair to bed, using a Hoyer lift (full body lift) from a bed, two caregiver assist of resident off the floor, and car transfer.<br><br>On November 13, 2024, at 8:25 a.m., clinical nurse supervisor (CNS)-A stated, "That is not okay," and stated she thought the orientation for staff included discussion about not transporting residents on the four-wheeled walker. CNS-A stated they needed to "do some reminders about that."<br><br>On November 13, 2024, at 8:45 a.m., ULP-L stated R8 was admitted yesterday, and when he attempted to go to the dining room this morning, he complained of feeling dizzy. ULP-L stated she didn't have access to a wheelchair so she grabbed the walker and had him sit to keep him safe. ULP-L stated she wouldn't normally transport a resident on the seat of a four-wheeled walker, but R8 was dizzy. ULP-L stated, "I'm new here," and stated she worked in a long term care facility prior to her recent start here with the | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 26903 | A. BUILDING: _____ B. WING _____ | 11/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

| (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 |
|---|---|---|---|---|
| 02320 | Continued From page 81<br><br>licensee. ULP-L stated she didn't know if she was told that she shouldn't transport a resident on the seat of a four-wheeled walker, but stated it would have been safer to have stayed with R8 and asked someone to bring a wheelchair. ULP-L again stated, "I'm new here."<br><br>Review of the Medline (a manufacturer of four-wheeled walkers) Rollator (another name for four-wheeled walker) Safety Guidelines, dated February 8, 2017, directed to ensure safety in using a rollator, the following safety information and all instructions must be followed:<br>- rollators are for individual use only and are NOT to be used as a wheelchair;<br>- DO NOT attempt to move the rollator while you or anyone is sitting on the seat;<br>- DO NOT self-propel the rollator while seated. Brakes must always be locked while the seat is in use;<br>- DO NOT use the seat to transport people or objects. DO NOT use the seat to carry or move anything;<br>- DO NOT use rollator as a wheelchair; and<br>- Serious injury to you and/or damage to the rollator frame or wheels may result from improper use.<br><br>The Training and Competency Evaluations for Unlicensed Personnel policy, revised July 28, 2021, indicated training and competency evaluations for all ULPs shall include safe transfer techniques and ambulation.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 26903 | A. BUILDING: _____ B. WING _____ | 11/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

| (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 |
|---|---|---|---|---|
| 02410 | Continued From page 82 | 02410 | | |
| 02410 SS=D | 144G.91 Subd. 13 Personal and treatment privacy<br><br>(a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan.<br>(b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan.<br>(c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of one resident (R7) observed during insulin administration.<br><br>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 | 02410 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 26903 | A. BUILDING: _____ B. WING _____ | 11/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

| (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 |
|---|---|---|---|---|
| 02410 | Continued From page 83<br><br>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).<br><br>The findings include:<br><br>R7 had diagnoses including diabetes.<br><br>R7's Service Plan, printed November 14, 2024, indicated R7 received services including blood sugar checks twice daily and as needed, and insulin administration four times daily.<br><br>R7's prescriber orders, dated October 11, 2024, included blood sugar checks twice daily and as needed, and NovoLog (short acting insulin) Flexpen 12 units subcutaneously (under the skin) three times daily with meals.<br><br>On November 13, 2024, at 7:37 a.m., R7 was seated in her wheelchair in the common area, being escorted to breakfast. Several residents were also headed to the dining room for the breakfast meal. Unlicensed personnel (ULP)-K approached R7 and announced that she was needed to give her insulin before breakfast. ULP-K asked that R7 be brought to the "green room [a room used for staff work room]." R7 was brought into the room backwards so she faced the door. The room was directly across from the dining room, had a door that could be shut which ULP-K shut, and had two windows. Residents, staff, and visitors walking by to the dining room could easily see into this room through the windows. With gloves on, ULP-K dialed the insulin pen to 12 units, pulled up R7's shirt to expose her abdomen, and gave the insulin injection into her abdomen. When interviewed, ULP-K stated she didn't normally bring residents | 02410 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 26903 | A. BUILDING: _____ B. WING _____ | 11/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CEDAR CREST OF SILVER LAKE | 1401 MAIN STREET WEST SILVER LAKE, MN 55381 |

| (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 |
|---|---|---|---|---|
| 02410 | Continued From page 84<br><br>into the "green room," but she wanted to make sure R7 got her insulin before eating.<br><br>On November 13, 2024, at 8:18 a.m., clinical nurse supervisor (CNS)-A stated residents should be taken to their rooms for procedures, to ensure their privacy, or they would consider putting curtains on the "green room" windows.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02410 | | |

Minnesota Department of Health
Food, Pools, and Lodging Services
12 Civic Center Plaza
Mankato, MN 56001
507-344-2700

Type: Full
Date: *11/12/24*
Time: 11:14:34
Report: 7990241003

# Food and Beverage Establishment Inspection Report



**Location:**
Cedar Crest of Silver Lake
1401 Main Street West
Silver Lake, MN55381
Mc Leod County, 43

**Establishment Info:**
ID #: 0024574
Risk: High
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**
Cedar Crest Estates, Inc.

Phone #: 3203276577
ID #: 31515

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.

AT THE TIME OF INSPECTION TWO CONTAINERS IN THE KITCHEN REACH IN COOLER WITH POTATOES AND TATOR TOT HOTDISH WERE NOT DATEMARKED. THEY WERE PREPARED YESTERDAY.

*Corrected on Site*

**Surface and Equipment Sanitizers**

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE SANITIZING AT 160 DEGREES F
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REACH IN COOLER POTATOES 40 DEGREES F
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: WALK IN COOLER STRAWBERRIES 38 DEGREES F
Violation Issued: No

Type: Full
Date: *11/12/24*
Time: 11:14:34
Report: 7990241003
Cedar Crest of Silver Lake

# Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 160 Degrees Fahrenheit - Location: MARAINARA SAUCE 160 DEGREES F
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: 0 Degrees Fahrenheit - Location: 0 DEGREES F
Violation Issued: No

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

**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 7990241003 of 11/12/24.

Certified Food Protection Manager: John H. Beck

Certification Number: 24518 Expires: 03/31/25

**Inspection report reviewed with person in charge and emailed.**

Signed: Emailed
Establishment Representative

Signed: Beyn D. Dorh
7990

651-201-4500
health.foodlodging@state.mn.us

Report #: 7990241003

# Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
12 Civic Center Plaza
Mankato, MN 56001

| | | | |
|---|---|---|---|
| No. of RF/PHI Categories Out | 1 | Date | 11/12/24 |
| No. of Repeat RF/PHI Categories Out | 0 | Time In | 11:14:34 |
| Legal Authority MN Rules Chapter 4626 | | Time Out | |

| Cedar Crest of Silver Lake | Address: 1401 Main Street West | City/State: Silver Lake, MN | Zip Code: 55381 | Telephone: 3203276577 |
|---|---|---|---|---|
| License/Permit #: 0024574 | Permit Holder: Cedar Crest Estates, Inc. | Purpose of Inspection: Full | Est Type: | Risk Category: H |

## FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

## GOOD RETAIL PRACTICES

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

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

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

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

**Food Recalls:**

**Person in Charge (Signature)** Emailed **Date:** 11/13/24

Inspector (Signature) Bryn D. Dorhi