STATE LICENSING COMPLIANCE REPORT

Report #: HL269031534C

Date Concluded: July 2, 2026

Name, Address, and County of Facility Investigated:
Cedar Crest of Silver Lake
1401 Main Street West
Silver Lake, MN, 55381
McLeod County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

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 _____	C 06/29/2026

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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: HL269031534C On June 29, 2026, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 39 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for HL269031534C, tag identification 0990, 1040.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 990 SS=D	144G.52 Subd. 2 Prerequisite to termination of a contract	0 990		

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0 990	Continued From page 1 (a) Before issuing a notice of termination of an assisted living contract, a facility must schedule and participate in a meeting with the resident and the resident's legal representative and designated representative. The purposes of the meeting are to: (1) explain in detail the reasons for the proposed termination; and (2) identify and offer reasonable accommodations or modifications, interventions, or alternatives to avoid the termination or enable the resident to remain in the facility, including but not limited to securing services from another provider of the resident's choosing that may allow the resident to avoid the termination. A facility is not required to offer accommodations, modifications, interventions, or alternatives that fundamentally alter the nature of the operation of the facility. (b) For a termination pursuant to subdivision 3 or 4, the meeting must be scheduled to take place at least seven days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting. (c) For a termination pursuant to subdivision 5, the meeting must be scheduled to take place at least five days before a notice of termination is issued. The facility must make reasonable efforts to ensure that the resident, legal representative, and designated representative are able to attend the meeting. (d) The facility must notify the resident that the resident may invite family members, relevant health professionals, a representative of the Office of Ombudsman for Long-Term Care, a representative of the Office of Ombudsman for Mental Health and Developmental Disabilities, or other persons of the resident's choosing to	0 990		

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0 990	Continued From page 2 participate in the meeting. For residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the facility must notify the resident's case manager of the meeting. (e)In the event of an emergency relocation under subdivision 9, where the facility intends to issue a notice of termination and an in-person meeting is impractical or impossible, the facility must use telephone, video, or other electronic means to conduct and participate in the meeting required under this subdivision and rules within Minnesota Rules, chapter 4659. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to schedule and participate in a meeting with the resident and the resident's legal representative and designated representative prior to termination of a contract for one of one resident (R1) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included osteoarthritis, depression, opioid dependency, and anxiety. R1 admitted to services on January 15, 2026,	0 990		

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0 990	Continued From page 3 R1's signed service plan dated January 15, 2026, indicated R1 received medication management, orientation prompting, dining reminders, and housekeeping. R1's progress notes dated April 1, 2026, indicated R1 returned from the emergency room with order to continue previously prescribed antibiotics (Levaquin). No signs of pneumonia on chest x-ray, Viral studies negative for COVID, Influenza, and RSV. Return for worsening weakness, shortness of breath, cough or other concerning or developing symptoms. R1's progress notes dated April 2, 2026, indicated R1 was sent back into the emergency room and was admitted for observation. R1's progress notes dated April 4, 2026, indicated a notice of emergency relocation was emailed to R1's case worker and ombudsman due to R1's current hospitalization. R1's progress notes dated April 6, 2026, indicated there was no plan for discharge from the hospital at this time. R1 admitted for altered mental status currently was on a psychiatric hold. Another entry this same day indicated R1's case worker was updated due to medications found in R1's room not prescribed. R1's progress notes dated April 10, 2026, indicated an emergency eviction notice was served on R1 due to exacerbation of her addiction and bringing into the licensee unprescribed drugs resulting in R1's altered mental status and posing vulnerability and danger to herself, other residents, and licensee staff. R1's case worker was in agreement. R1's eviction notice was faxed to the hospital's inpatient mental	0 990		

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0 990	Continued From page 4 health. R1's Eviction Notice dated April 10, 2026, indicated the licensee staff had a conference call on April 10, 2026, with R1's case worker regarding R1's change to altered mental status. It was determined R1 was a harm to herself, to other residents, and to staff at the facility. It was discussed and determined the licensee would serve this eviction notice effective immediately for the well-being of all parties involved. The notice indicated the following: -The termination was necessary for the person's welfare, and the facility cannot meet the person's needs -The safety of the person or others who receive services is endangered, and the provider attempted to use positive support strategies but has not achieved and effectively maintained safety. -The health of the person or others who receive services is endangered. -The resident had an exacerbation of her addiction which has resulted in an altered mental state making her a danger to herself and the other residents. The same Eviction Notice included the phone numbers and emails for the Ombudsman office and identified an appeals process. R's discharge summary dated April 10, 2026, indicated R1 received housing with services for laundry, housekeeping, meals, medication distribution and management. The reason for discharge the licensee indicated that they were unable to meet resident's needs, and "other". Illegal drugs were in R1's system requiring a 1:1.	0 990		

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0 990	Continued From page 5 R1's record did not include evidence that the licensee conducted the required meeting with the resident and the resident's legal representative and designated representative at least seven days prior to evicting and terminating R1's contract on April 10, 2026. During an interview on June 30, 2026, at 10:22 a.m., registered nurse (RN)-A and licensed practical nurse (LPN)-B both stated R1 discharged from the licensee while in the hospital. R1 was found to have had illicit drugs (fentanyl) in her system and the licensee was concerned R1 had drugs in her room not prescribed. When asked if the licensee had a pre-termination meeting prior to R1's eviction on April 10, 2026, RN-A stated R1's case worker and the hospital social worker were all in agreement R1 needed a different place to live. RN-A stated the licensee could not assist R1 in fighting her addiction. RN-A stated R1's case worker had the discussion with R1 about the eviction. During as interview on June 30, 2026, at 10:45 a.m., owner (OW)-C, stated he believed the licensee may have had a pre-termination meeting prior to R1's eviction on April 10, 2026, however he would need to double check if he could locate any records of that and would fax. A fax received from the licensee on June 30, 2026 at 11:47 a.m., included R1's same progress notes with the entries dated April 6, and April 10, 2026. The licensee provided policy titled Emergency Relocation, dated Decemebr 12, 2024, indicated following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination	0 990		

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0 990	Continued From page 6 process. The policy did not include scheduling and participating in a meeting with the resident and the resident's legal representative and designated representative before terminating an assisted living contract. TIME PERIOD FOR CORRECTION: Seven (7) days	0 990		
01040 SS=D	144G.52 Subd. 7 Notice of contract termination required (a) A facility terminating a contract must issue a written notice of termination according to this section. The facility must also send a copy of the termination notice to the Office of Ombudsman for Long-Term Care and, for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, to the resident's case manager, as soon as practicable after providing notice to the resident. A facility may terminate an assisted living contract only as permitted under subdivisions 3, 4, and 5. (b) A facility terminating a contract under subdivision 3 or 4 must provide a written termination notice at least 30 days before the effective date of the termination to the resident, legal representative, and designated representative. (c) A facility terminating a contract under subdivision 5 must provide a written termination notice at least 15 days before the effective date of the termination to the resident, legal representative, and designated representative. (d) If a resident moves out of a facility or cancels services received from the facility, nothing in this section prohibits a facility from enforcing against the resident any notice periods with which the	01040		

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01040	Continued From page 7 resident must comply under the assisted living contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to issue a written notice for a termination of contract at least 15 days ahead of an expedited termination, for one of one resident (R1) with records reviewed. In addition, the licensee failed to send a copy of a termination notice to the Office of Ombudsman for Long Term Care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included osteoarthritis, depression, opioid dependency, and anxiety. R1 admitted to services on January 15, 2026, R1's signed service plan dated January 15, 2026, indicated R1 received medication management, orientation prompting, dining reminders, and housekeeping. R1's progress notes dated April 10, 2026, indicated an emergency eviction notice was served on R1 due to exacerbation of her addiction and bringing into the licensee unprescribed drugs resulting in R1's altered	01040		

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01040	Continued From page 8 mental status and posing vulnerability and danger to herself, other residents, and licensee staff. R1's case worker was in agreement. R1's eviction notice was faxed to the hospital's inpatient mental health. R1's Eviction Notice dated April 10, 2026, indicated the licensee staff had a conference call on April 10, 2026, with R1's case worker regarding the resident change of altered mental status. It was determined that R1 was a harm to herself, to other residents, and to staff at the facility. It was discussed and determined that the licensee would serve this eviction notice effective immediately for the well-being of all parties involved. The notice indicated the following: -The termination was necessary for the person's welfare, and the facility cannot meet the person's needs -The safety of the person or others who receive services is endangered, and the provider attempted to use positive support strategies but has not achieved and effectively maintained safety. -The health of the person or others who receive services is endangered. -The resident had an exacerbation of her addiction which has resulted in an altered mental state making her a danger to herself and the other residents. The same Eviction Notice included the phone numbers and emails for the Ombudsman office and identified an appeals process. The licensee's discharge roster indicated R1 discharged on April 10, 2026, to a higher level of care and identified location as a hospital.	01040		

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01040	Continued From page 9 R1's record did not include evidence the licensee issued a written notice of termination of contract 15 days prior to terminating services. R1's record did not include evidence the licensee notified the Office of Ombudsman for Long-Term Care of R1's eviction/discharge. During an interview on June 26, 2026, at 3:55 p.m., owner (OW)-C stated the licensee presented R1 with an eviction on April 10, 2026. OW-A stated this was discussed with R1's case manager. OW-C stated the licensee did not send a written notice of R1's termination of contract to the Ombudsman. The licensee provided policy titled Emergency Relocation dated December 12, 2024, indicated following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process. The licensee provided policy titled Termination Protections, dated July 1, 2025, did not include the licensee issuing a written notice of a termination of contract at least 30 days ahead of the termination, or at least 15 days ahead of an expedited termination, or sending a copy of the notice to the Office of Ombudsman for Long-Term Care. TIME PERIOD FOR CORRECTION: Seven (7) days	01040		