

STATE LICENSING COMPLIANCE REPORT

Report #: HL24253001C **Date Concluded:** May 2, 2022

Name, Address, and County of Facility Investigated:

The Cedars
701 Polk Street
Anoka, MN 55303
Anoka County

Facility Type: Assisted Living Facility (ALF) Evaluator's Name:

Maerin Renee, RN, Special Investigator James Larson, 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.

Minnesota Department of Health

STATEMENT OF DEFICIENT AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7. 50.25.110.		С
		24253	B. WING		04/26/2022
NAME OF PROVIDER OR	SUPPLIER		,	STATE, ZIP CODE	
THE CEDARS		701 POLK ANOKA, N	STREET IN 55303		
PREFIX (EACH D	EFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
0 000 Initial Com	ments		0 000		
Initial comme ******ATTE ASSISTED CORRECT In accordant 144G.08 to issued pure Determination requires comprovided at When a Mitems, failuble consider INITIAL COMPANIES AND April 26 Health companies are investigation services un Facility lice.	nents NTION* LIVING TON OR nce with 144G.9 suant to tion of with mpliance the state innesota re to core red lack OMMEN OUTC 0, 2022, to ducted a vider, and issued. A vider, and issued. A on, there nce here on the nse. ng corre outc, tag	PROVIDER LICENSING DER Minnesota Statutes, section 5, these correction orders are a complaint investigation. hether a violation is corrected e with all requirements ute number indicated below. Statute contains several mply with any of the items will of compliance. TS: the Minnesota Department of a complaint investigation at the did the following correction At the time of the complaint were 6 residents receiving providers Assisted Living ction orders are issued for gidentification 0510, 0700,		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Assist Living Facilities. The assigned tag appears in the far left column entire Prefix Tag." The state Statute number the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficiency Column. This column also includes findings which are in violation of the requirement after the statement," Minnesota requirement is not met evidenced by." Following the evaluation for Column States, "Provider's Plan of Correction." This Applies of Correction." This Applies of Federal Deficiencies only. WILL Appear on Each Page. There is no requirement is not met evidenced by the Third States of the	oftware. I to sted number tled "ID nber and e Statute sies" s the ne state This as uators ' rrection. DING OF THIS OON FOR TATE UMN IS SES AND EVEL
0 510 144G.41 S SS=F Minnesota Department of H		fection control program	0 510		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER THE CEDARS TO POLK STREET ANDKA, MN 55303 [X4] ID PRETTX [EACH DEPICIENCY MUST SEE PRECEDED BY FULL PRETTY AND CORRECTION AND CORRECTION AND STATE PROVIDERS PLAN OF CORRECTION AND STATE PRESENT AND COMPLETE PREVIOUS PRETTY AND COMPLETE PREVIOUS PRETTY AND COMPLETE PREVIOUS PROVIDERS PREVIOUS PROVIDERS PRAN OF CORRECTION AND COMPLETE PREVIOUS PROVIDERS PREVIOUS PROVIOUS PREVIOUS PREVIOUS PREVIOUS PREVIOUS PROVIN		EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SI PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:					
CALL DEPART			24253	B. WING			
Continued From page 1 Cont	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 0 510 Continued From page 1 (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 (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 long-term care facilities and, as applicable, for infection prevention and control in long-term care facilities and, as applicable for infection prevention and control in long-term care facilities and, as applicable for infection prevention and control in long-term care facilities and infection control policies and procedures that complied with accepted health care, medical, and nursing standards for infection control related to the COVID-19 pandemic when the facility failed to ensure visitors, employees, and residents were screened for COVID-19 with temperature checks and screening questions and failed to develop policies and procedures to guide decision making related to COVID-19 pandemic. This practice resulted in a level two violation (a violation that did not harm 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 all residents.	THE CE	DARS					
(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. (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 long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to establish and maintain infection control policies and procedures that complied with accepted health care, medical, and nursing standards for infection control related to the COVID-19 pandemic when the facility failed to ensure visitors, employees, and residents were screened for COVID-19 pandemic when the facility failed to ensure visitors, employees, and residents were screened for COVID-19 pandemic. This practice resulted in a level two violation (a violation that did not harm 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 all residents.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETE
The findings include: On April 26th, at 9:45 a.m., unlicensed personnel (ULP)-C met two Minnesota Department of	0 510	(a) All assisted livin maintain an infection complies with accernursing standards of (b) The facility's infectional Centers for Prevention (CDC) of control in long-term applicable, for infectional centers for assisted living facility (c) The facility must compliance with this This MN Requirements by: Based on observation review, the facility of infection control policity of infection control	g facilities must establish and on control program that pted health care, medical, and for infection control. Ection control program must be ent guidelines from the representation prevention and care facilities and, as etion prevention and control in ties. It maintain written evidence of a subdivision. The subdivision and record ailed to establish and maintain licies and procedures that pted health care, medical, and for infection control related to demic when the facility failed to ployees, and residents were D-19 with temperature checks etions and failed to develop dures to guide decision making 9 pandemic. The subdivision control related to demic when the facility failed to ployees, and residents were D-19 with temperature checks etions and failed to develop dures to guide decision making 9 pandemic. The subdivision control related to develop dures to guide decision making 9 pandemic. The subdivision control related to develop dures to guide decision making 9 pandemic. The subdivision control related to develop dures to guide decision making 9 pandemic. The subdivision control related to develop dures to guide decision making 9 pandemic. The subdivision control related to develop dures to guide decision making 9 pandemic.				

Minnesota Department of Health

STATE FORM XBBC11 If continuation sheet 2 of 11

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: A. BUILDING:					
		24253	B. WING		04/2) 6/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE CEDARS		701 POLK ANOKA, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 510	Continued From pa	ge 2	0 510			
	the facility. ULP-C	eyors at the entrance inside of lid not screen the MDH D-19 with a temperature ning questions.				
	registered nurse (R screenings for COV employees, and vis date. A COVID-19 s available at the entrall employee / visito for COVID-19 symp. The document instremployee has a ten	, at approximately 11:00 a.m., N)-A acknowledged (ID-19 with residents, itors had not occurred this screening document was rance requiring documenting or temperatures and screening otoms at the start of your shift, ucted to call the nurse if an apperature over 100.4 degrees symptoms of COVID-19.				
	March 13, 2020, incorprofessional visits was all symptoms of CO	Screening policy dated dicated all visitors including will be screened upon entry for OVID-19 including checking and pulse oximetry will be				
	No further informati	on provided.				
	Time Period for Cor	rection: Two (2) Days				
0 700 SS=F		n 1 Resident record	0 700			
	(b) Resident record electronic, must be tampering, or unaut compliance with charelevant federal and establish and imple control use, storage	s, whether written or protected against loss, shorized disclosure in apter 13 and other applicable state laws. The facility shall ment written procedures to e, and security of resident sh criteria for release of the security of the securi				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	CONSTRUCTION	(X3) DATE COMI	SURVEY PLETED
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	24253	B. WING			26/2022
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
THE CEDARS		STREET MN 55303			
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0 700 Continued From pa	age 3	0 700			
by: Based on observate review, the facility for records were protested disclosure when restored in an open of the stored in an open open open open open open open ope	ent is not met as evidenced ion, interview, and record ailed to ensure resident cted against unauthorized sident medical records were abinet in a public area. This affect all residents residing in				
violation that did no safety but had the resident's health or widespread scope or represent a syst	ted in a level two violation (a of harm a resident's health or potential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected I to affect a large portion or all				
The findings includ	e:				
charts were stored area. The shelves door or lock. The cinformation including provider appointment medications, and parts were according to the charts were stored.	at 10:00 a.m., resident medical on shelves in a main living were in an open cubby with no charts contained resident ng health assessments, ents, prescriptions and ersonal contact information. Ecessible to unauthorized rts were not securely stored.				
registered nurse/di	at approximately 12:00 p.m., rector of nursing (RN)-A stated uld be locked up and authorized viewers.				
policy, dated Augus	Record-Security and Storage st 1, 2021, indicated resident nt information will be stored				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		24253	B. WING		04/2) 26/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1	
THE CED	ARS	701 POLK	,			
	JANS	ANOKA, I	MN 55303			ı
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 700	Continued From pa	ge 4	0 700			
	and secured in an a staff will have acces	area where only authorized ss.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
01460 SS=F		n 1 Orientation of staff and	01460			
	must complete an of facility licensing required before providing as residents. The orientation need on	nd supervising direct services brientation to assisted living uirements and regulations sisted living services to ntation may be incorporated uired under subdivision 5. The ly be completed once for each not transferable to another				
	by: Based on interview licensee failed to end living licensing requiprovided for two of personnel (ULP-(C) reviewed. This had	and record review, the sure orientation to assisted irements and regulations was two employees, unlicensed and ULP-D, with records the potential to affect all assisted living services.				
	violation that did no safety but had the president's health or widespread scope (or represent a system or has the potential the residents).	ed in a level two violation (a t harm a resident's health or ootential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings include	e :				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		24253	B. WING	5 C 04/26/2) 6/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE CEDARS ANOKA, N			STREET IN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01460	Continued From pa	ge 5	01460			
	comprehensive hor providing assisted liver residents on August training records lack	ecember 18, 1998, under the ne care license. ULP-C began iving services to licensee's t 1, 2021. ULP-C's employee ked evidence of successful ted living orientation in 4G statutes.				
	comprehensive hor providing assisted li 2021. ULP-D's emperence of successions	n July 5, 2017, under the ne care license. ULP-D began iving services on August 1, loyee training records lacked sful completion of assisted accordance with 144G				
	nurse/director of nu	at 12:00 p.m., registered rsing (RN)-A stated orientation do not been completed.				
	The facility did not horientation policy red					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
01470 SS=F	144G.63 Subd. 2 C	ontent of required orientation	01470			
	topics: (1) an overview of the (2) an introduction as policies and proced of assisted living separation;	must contain the following his chapter; and review of the facility's ures related to the provision ervices by the individual staff rgencies and use of				

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NAME OF PROVIDER OR SUPPLIER THE CEDARS STREET ADDRESS, CITY, STATE, ZIP CODE 701 POLK STREET ANOKA, MN 55303 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 01470 Continued From page 6 emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE CEDARS TO1 POLK STREET ANOKA, MN 55303 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) O1470 Continued From page 6 emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints,					c	;
THE CEDARS Tot Polk Street ANOKA, MN 55303 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)		24253	B. WING		04/2	6/2022
ANOKA, MN 55303 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 01470 Continued From page 6 emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints,	NAME OF PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE O1470 Continued From page 6 emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints,	THE CEDARS					
emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints,	PREFIX (EACH DEFICIENCY MUST	T BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
Facility Complaints; (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 (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations,	emergency services; (4) compliance with and maltreatment of vulnerate 626.557 to the Minnesota Center (MAARC); (5) the assisted living bill responsibilities related to and protection of those rition (6) the principles of personal service delivery and support services provide (7) handling of residents' complaints, and where to including information on Facility Complaints; (8) consumer advocacy of Combudsman for Mental Developmental Disabilities Ombudsman at the Depastervices, county-manage other relevant advocacy (9) a review of the types services the employee we facility's category of licentation may also conservices to residents with training on hearing loss pubdivision must be high based, may include onlininclude training on one of topics: (1) an explanation of age and how it manifests itset the challenges it poses to (2) health impacts related age-related hearing loss.	reporting of the ble adults under section a Adult Abuse Reporting I of rights and staff of ensuring the exercise rights; on-centered planning how they apply to direct ed by the staff person; complaints, reporting of oreport complaints, the Office of Health and es, Managed Care artment of Human ed care advocates, or services; and of assisted living will be providing and the asure. It is in paragraph (a), itain training on providing the hearing loss. Any provided under this in quality and research the training, and must be more of the following e-related hearing loss elf, its prevalence, and to communication; it do untreated, such as increased	01470			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		24253	B. WING		04/2	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	04/2	26/2022
THE CEDARS		701 POLK	STREET			
		<u> </u>	MN 55303			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01470	Continued From pa	ge 7	01470			
	that may enhance of involvement, including assistive listening of and tactile alerting of access in real time, This MN Requirements by: Based on interview failed to ensure oried licensing requirements provided for two of personnel (ULP-(C)) records reviewed.	ut strategies and technology				
	violation that did no safety but had the president's health or widespread scope (or represent a system)	ed in a level two violation (a t harm a resident's health or otential to have harmed a safety) and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
	The findings include	e:				
	comprehensive hor	ecember 18, 1998, under the ne care license. ULP-C began iving services to licensee's t 1, 2021.				
	comprehensive hor	n July 5, 2017, under the ne care license. ULP-D began iving services on August 1,				
	ULP-C and ULP-D's	s employee training records				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	 ` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		24253	B. WING		1	26/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
THE CE	DARS		STREET MN 55303			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON.	(VE)
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01470	Continued From pa	ge 8	01470			
	-An overview of 144 -An introduction and policies and proced assisted living servi	d review of the facility's ures related to the provision of ces encies and use of emergency and reporting of the				
	-The assisted living -The principles of poservice delivery -Handling of resider complaints, and where advocated the complaints of the comp	bill of rights erson-centered planning and at complaints, reporting of ere to report complaints by services of the office of the ng-Term Care, Office of ental Health and abilities, Managed Care Department of Human anaged care advocates, or cacy services es of assisted living services e providing and the facility's				
	nurse/director of nute to 144G statutes had to 144G assisted living	• •				

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Minnesota Department of Health

STATEMENT OF DEFI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		24253	B. WING		04/2	6/2022
NAME OF PROVIDER	OR SUPPLIER		,	STATE, ZIP CODE		
THE CEDARS			(STREET VIN 55303			
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01880 Continu	ed From pa	ige 9	01880			
01880 144G.7 SS=F	1 Subd. 19	Storage of medications	01880			
prescrip substant according permit of the second pe	otion medical tially construction the machine facility fa	acility must store all ations in securely locked and fucted compartments anufacturer's directions and zed personnel to have access. ent is not met as evidenced ion, interview and record ailed to ensure prescription was secure. This had the II residents. ed in a level two violation (a of harm a resident's health or cotential to have harmed a safety), and was issued at a (when problems are pervasive emic failure that has affected to affect a large portion or all				
The find	dings include	e:				
were m commo with a k refrigera which in	ade of a ref n living area ey style pac ator. The me	at 10:30 a.m. observations rigerator located in the which was left unsecured llock placed on top of the edications in the refrigerator, alin, could be accessed by all ors.				
a.m. un refrigera not prop	licensed pe ator contain	on April 26, 2022, at 10:30 rsonnel (ULP)-C verified the ing residents medication was and locked the refrigerator				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		24253	B. WING		04/26	5/2022
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 04/20	JI ZUZZ
THE CE	DARS	701 POLK ANOKA, N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01880	Continued From pa	ge 10	01880			
	May 1, 2015, indica	led Medication Policies, dated ted all medications that are r-the-counter, will be stored in cabinets.				
	TIME PERIOD FOR (14) days.	R CORRECTION: Fourteen				
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