



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 9, 2024

Licensee
Creekside Villas
1177 117th Avenue
Coon Rapids, MN 55448

RE: Project Number(s) SL3499015

Dear Licensee:

On January 2, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 31, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Casey DeVries'.

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 7, 2023

Licensee
Creskide Villas
1177 117th Avenue
Coon Rapids, MN 55448

RE: Project Number(s) SL34994015

Dear Licensee:

On November 20, 2023, 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 August 31, 2023. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 31, 2023 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 31, 2023, found not corrected at the time of the November 20, 2023, follow-up survey and/or subject to penalty assessment are as follows:

0830-Local Laws Apply-144g.45 Subd. 3 = \$3,000.00
1290-Background Studies Required-144g.60 Subdivision 1 = \$3,000.00
2310-Appropriate Care And Services-144g.91 Subd. 4 (a) = \$3,000.00

The details of the violations noted at the time of this follow-up survey completed on November 20, 2023 (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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$9,000.00**. 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.

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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:

<https://www.web.health.state.mn.us/form/HRD-Appeals-Form>

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 MDH 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://www.web.health.state.mn.us/form/HRD-Appeals-Form>**.

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 Casey DeVries at 651-201-5917.

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,

A handwritten signature in black ink that reads "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" and last name "DeVries" clearly distinguishable.

Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/20/2023
NAME OF PROVIDER OR SUPPLIER CREEKSIDE VILLAS ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1177 117TH AVENUE COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34994015-1 On November 20, 2023, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 31, 2023. At the time of the survey, there were seven residents: seven receiving services under the Assisted Living license. As a result of the revisit, 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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.		
{0 100} SS=C	144G.10 Subdivision 1 License required (a)(1)?Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is	{0 100}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 100}	Continued From page 1 licensed under this chapter.? (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e).? (b)?The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.? (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e).? (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.? (e) Upon approving an application for an assisted living facility license, the commissioner may:? (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or? (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.	{0 100}			

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{0 100}	Continued From page 2 This MN Requirement is not met as evidenced by: No further action required.	{0 100}			
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1;	{0 250}			

Minnesota Department of Health

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{0 250}	Continued From page 3 (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: No further action required	{0 250}			
{0 430} SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not	{0 430}			

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{0 430}	Continued From page 4 provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: No further action required	{0 430}			
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the	{0 470}			

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{0 470}	Continued From page 5 facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: No further action required	{0 470}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action required	{0 480}			
{0 580} SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time	{0 580}			

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{0 580}	Continued From page 6 of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: No further action required	{0 580}			
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: No further action required	{0 640}			
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	{0 680}			

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{0 680}	Continued From page 7 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required	{0 680}			
{0 790} SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced	{0 790}			

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{0 790}	Continued From page 8 by: No further action required	{0 790}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: No further action required	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year	{0 810}			

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{0 810}	Continued From page 9 thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required	{0 810}			
{0 830} SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking all residents. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	{0 830}			

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{0 830}	Continued From page 10 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 has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 20, 2023, at 9:00 a.m., the surveyor observed open garage doors on side A (house number 1177) and side B (house number 1173) of the licensee. The layout of the facility was a side-by-side duplex style residential home with a connecting hallway in-between. The two attached garages also had a shared wall. Side B In the garage of side B, the surveyor observed a card table with two chairs around the table. On the card table, the surveyor observed an ash tray containing multiple cigarette butts. The side B garage was observed to contain multiple items that were potentially flammable including a battery-operated power chair, a twin sized box spring, as well as miscellaneous furniture and stored items. Above the card table in the side B garage, the surveyor observed a no smoking posting. Side A On the side A garage, the surveyor observed an ash tray with multiple cigarette butts. The ash tray was placed on top of a stool. The side A garage was observed to contain multiple items that were potentially flammable including garbage receptacles, multiple walkers,	{0 830}			

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{0 830}	Continued From page 11 as well as miscellaneous furniture and other stored items. The surveyor observed a no smoking sign in the garage as well as a fire extinguisher. On November 20, 2023, at 9:10 a.m., unlicensed personnel (ULP)-C stated he was under the impression that because the garage side B was ventilated, heated, and properly insulated, that smoking would be allowed. ULP-C stated that residents still smoke in both garages of the licensee, and that the garage on side A has not yet been ventilated or heated. ULP-C further stated they were aware that residents were still smoking in both garages. On November 20, 2023, at 12:29 p.m., LALD-A stated all but one resident residing within the facility smoked and routinely used the garage of the facility to smoke. Additionally, LALD-A stated that they were aware that residents were using the garages in the facility to smoke. LALD-A stated that they had provided appropriate smoking locations with appropriate ash trays but had been unable to obtain compliance with using these locations. In addition, LALD-A stated the vent and heater in the garage were installed on side B without consulting with the Fire Marshal or the Minnesota Department of Health. The licensee Smoking policy dated September 13, 2023, indicated the following: - Smoking is prohibited indoors. Smoking is permitted only in outdoor spaces where it is designated. - The Licensed Assisted Living Director and the CEO have the authority to designate an area of the facility as a smoking area. - Smoking is prohibited in any area where oxygen or other combustible material is being used or	{0 830}			

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{0 830}	Continued From page 12 stored, in any area that bears a "No-Smoking" sign, or in any area that would create a hazardous or unsafe condition. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited indoors of all public places to include health care facilities and clinics. MCIIA defined "Indoor Area" to be "a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows (open or closed) around the perimeter. A wall includes retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. A (standard) window screen is not a wall." Minnesota State Statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided.	{0 830}			
{0 900} SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms	{0 900}			

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{0 900}	Continued From page 13 concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: No further action required	{0 900}			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (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.	{01060}			

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{01060}	Continued From page 14 (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (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 (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. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (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. (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 This MN Requirement is not met as evidenced by: No further action required	{01060}			

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{01060}	Continued From page 15	{01060}			
{01290} SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for three of six employees (maintenance personnel (M)-D, M-E, and owner (O)-F). 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 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).	{01290}			

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{01290}	Continued From page 16 The findings include: M-D M-D began working for the licensee on June 11, 2023. M-D's employee record lacked evidence to indicate the licensee had submitted a background study under the current assisted living license and affiliated to the licensee's health facility identification (HFID) number prior to the start of the survey. M-E M-E started working for the licensee on December 17, 2007, under the Comprehensive Home Care license until August 1, 2021, when the license changed to an Assisted Living license. M-E's employee record lacked evidence to indicate the licensee had submitted a background study under the current assisted living license and affiliated to the licensee's HFID number prior to the start of the survey. O-F O-F was the previous licensee owner under the Comprehensive Home Care license until August 1, 2021, when the license changed to an Assisted Living license. O-F's background study affiliated to HFID 34994, indicated "Eligible - COVID-19 Study - Expired" on the NETStudy 2.0 website roster page. On November 20, 2023, at 2:18 p.m., licensed assisted living director (LALD)-A stated O-F is the owner of the facility and has full access to the facility and residents as well as access to all buildings affiliated with the licensee.	{01290}			

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{01290}	Continued From page 17 On November 20, 2023, at 3:05 p.m., M-E stated M-E's role with the licensee was a maintenance supervisor and M-E routinely completed work on site within the facility in an unsupervised capacity. M-E stated M-E and M-D had full access to all buildings affiliated with the licensee. The Licensee's Background Studies policy dated August 1, 2021, read, "All employees; as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through DHS. Only those with satisfactory results will continue to work with the facility and its residents." No further information was provided.	{01290}			
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the	{01440}			

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{01440}	Continued From page 18 individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: No further action required	{01440}			
{01470} SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (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; (3) handling of emergencies and use of 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 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	{01470}			

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{01470}	Continued From page 19 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, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: No further action required	{01470}			
{01500} SS=F	144G.63 Subd. 5 Required annual training (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	{01500}			

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{01500}	Continued From page 20 provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (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 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (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; (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 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and	{01500}			

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{01500}	Continued From page 21 challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: No further action required	{01500}			
{01750} SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: No further action required	{01750}			
{01790} SS=D	144G.71 Subd. 10 Medication management for residents who will	{01790}			

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{01790}	Continued From page 22 (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; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (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. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (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 (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: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) 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	{01790}			

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{01790}	Continued From page 23 medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (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; (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 (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. This MN Requirement is not met as evidenced by: No further action required	{01790}			
{02240} SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the	{02240}			

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{02240}	Continued From page 24 Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: No further action required	{02240}			
{02290} SS=D	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights	{02290}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/20/2023
NAME OF PROVIDER OR SUPPLIER CREEKSIDE VILLAS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1177 117TH AVENUE COON RAPIDS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{02290}	Continued From page 25 available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: No further action required	{02290}			
{02310} SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of two residents (R2) with bed rails. 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 serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 20, 2023, at 9:05 p.m., the	{02310}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/20/2023
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{02310}	Continued From page 26 surveyor observed a bed rail on the side of R2's bed. The bed rail appeared to be a consumer bed rail mounted in between the box spring and mattress on the upper right side of the bed. The bed rail was in a lowered position and touching the floor, with the ability to be raised and lowered. The bed rail was not securely attached to bed and was able to be moved out from between the box spring and mattress with minimal effort. When asked about the use of the bed rail, R2 stated they utilized the bedrails while getting in and out of bed. R2 was admitted to the licensee on September 5, 2023. R2's diagnoses included cerebral infarct. R2's most recent assessment dated September 13, 2023, indicated R2 had no assistive devices for their bed. R2's record lacked: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; and - Evidence the licensee referred to the Consumer Product Safety Commission (CPSC) for the most up-to-date information related to portable bed rail	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 27 recall information. On November 20, 2023, at 12:29 p.m., licensed assisted living director (LALD)-A stated R2 received their new bed late on Friday evening (November 17, 2023) and one of their agency nurses had begun the bedrail assessment on Friday, but had not finished it yet. The surveyor requested the bedrail assessment once completed to ascertain whether the required content was included in the assessment. On November 20, 2023, at 3:17 p.m., LALD-A stated no bed rail assessment had been completed yet. The licensee's Bed-Side Rail policy, revised during the survey process and dated November 20, 2023, indicated the following: - Before and during side rail use, the RN conducts an assessment to identify the intended purpose of the siderail and the risks regarding the use of the side rail. - Assessments are done prior to bedrail use, every 90 days going forward, and with a change of condition that may affect the use of the bed rails. - Entrapment zones on a hospital bed must pass the FDA measurement guidelines when rails are in use. The Bionix- B4000 Bed Rail Measurement Device will be used following manufacturer's instructions to determine if the bed rail passes or fails FDA Zone measurements. Failed zones must be immediately corrected. - Manufacturer instructions for bed rail installation are to be available and followed. - If the side rail is acting as a restraint, appropriate action should be taken to educate residents, staff, and families, if appropriate, that this is not an acceptable use for side	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 28 rails. - A review of risks and consent to use a bed rail needs to be in place for use. Refusal to remove devices or sign consent must be documented. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated 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." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 29 the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". In addition, the MDH website indicated, "licensees should refer to the CSPC for the most up-to-date information related to portable bed side rail recall information." No further information provided.	{02310}			
{03090} SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: No further action required	{03090}			

Type: Follow-Up
Date: 11/20/23
Time: 13:00:00
Report: 1013231277

Food and Beverage Establishment Inspection Report

Page 1

Location:

Creekside Villas
1177 117th Avenue
Coon Rapids, MN55448
Anoka County, 02

Establishment Info:

ID #: 0037773
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637546899
ID #:

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

The following orders were issued during this inspection.

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

3-302.11A(1)

**** Priority 1 ****

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

11/20/23 REPEAT

2 CARTONS OF RAW SHELL EGGS WERE STORED ON THE TOP SHELF ABOVE READY-TO-EAT FOOD (MILK, JUICE, CHEESE) INSIDE THE KITCHEN A REFRIGERATOR. DISCUSSED FOOD STORAGE AND THE RAW EGGS WERE MOVED BELOW AND AWAY. ORDER WAS ISSUED ON 8/28/23.

Corrected on Site

2-100 Supervision

2-102.12AMN

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

11/20/23

NO STAFF HAD THE MN CFPM CERTIFICATE. ONE STAFF HAD A CURRENT FOOD MANAGER'S COURSE CERTIFICATE. DISCUSSED THE MN CFPM REQUIREMENT AND THE APPLICATION WAS PROVIDED. ORDER WAS ISSUED ON 8/28/23.

Comply By: 12/11/23

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

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

11/20/23 REPEAT

A BOX OF COFFEE WAS STORED ON THE FLOOR BELOW THE SINK IN KITCHEN B. DISCUSSED FOOD STORAGE WITH STAFF AND THE FOOD WAS MOVED TO A STORAGE

Type: Follow-Up
Date: 11/20/23
Time: 13:00:00
Report: 1013231277
Creekside Villas

Food and Beverage Establishment
Inspection Report

RACK. ORDER WAS ISSUED ON 8/28/23.
Corrected on Site

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

The inspection was completed with MDH J. Boettcher and the on-site staff, then reviewed with MDH Nurse Evaluators T. Brown and Z. Morth.

The inspection was completed to assess compliance with previous orders.

Discussed food storage, hand washing, MN certified food protection manager requirements, and food handling procedures.

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 1013231277 of 11/20/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Gabrielle Gallagher
Director

Signed:_____

Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 5, 2023

Licensee
Creekside Villas
1177 117th Avenue
Coon Rapids, MN 55448

RE: Project Number(s) SL34994015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 31, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of

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

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

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

St - 0 - 0830 - 144g.45 Subd. 3 - Local Laws Apply - \$3,000.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$9,000.00**. 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter

as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

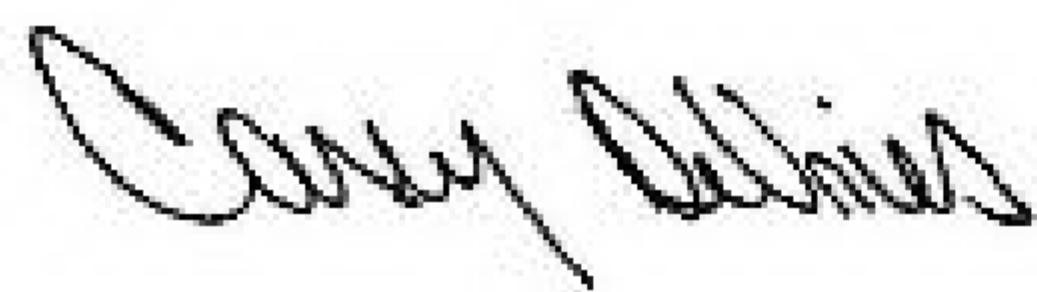
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH 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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/31/2023
NAME OF PROVIDER OR SUPPLIER CREEKSIDE VILLAS			STREET ADDRESS, CITY, STATE, ZIP CODE 1177 117TH AVENUE COON RAPIDS, MN 55448		
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34994015-0 On August 28, 2023, through August 31, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 6 active residents; all of whom were receiving services under the Assisted Living license. An immediate correction order was identified on August 29, 2023, issued for SL34994015-0, tag identification 0830. An immediate correction order was identified on August 29, 2023, issued for SL34994015-0, tag identification 2310. On August 30, 2023, the immediacy of correction order 0830 was removed, however non-compliance remained at a level three, widespread violation.	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 License Providers. 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 surveyors' 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 subd. 1, 2, and 3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/31/2023
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0 000	Continued From page 1 On August 30, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three, isolated violation. An immediate correction order was identified on August 30, 2023, issued for SL34994015-0, tag identification 1290. On August 31, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained at a level three, isolated violation. The correction order was amended following the issuance on August 30, 2023. See tag 1290 for details.	0 000			
0 100 SS=C	144G.10 Subdivision 1 License required (a)(1)?Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter.? (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e).? (b)?The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.? (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e).? (d) Upon approving an application for an assisted living facility license, the commissioner may issue	0 100			

Minnesota Department of Health

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0 100	Continued From page 2 a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.? (e) Upon approving an application for an assisted living facility license, the commissioner may:? (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or? (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to identify the street address associated with each building being utilized by the licensee under their health facility identification number (HFID) 34994. 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). The findings include:	0 100			

Minnesota Department of Health

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0 100	Continued From page 3 The licensee held an Assisted Living license effective January 1, 2023, for a capacity of eight residents. The licensee's initial (conversion) application dated May 28, 2021, indicated the licensee was licensing one building at one address with one property number [1177]. The licensee's renewal application dated May 28, 2021, indicated the licensee was licensing a single building address of 1177. During the entrance conference on August 28, 2023, at 11:05 a.m., with licensed assisted living director (LALD)-A, it was identified there were two mailing addresses, one for each side of the building that was connected through a hallway between two laundry room areas. Each mailing address 1173 and 1177 consisted of a complete facility unit that housed four residents for a total of eight under one HFID 34994. The building had an internal door that the licensee could shut to close off and make two individual units, however, the door was generally left open to make one large, connected space. The main entrance to the buildings were identified as addresses 1173 and 1177. On August 28, 2023, at 11:40 a.m., LALD-A stated, "Right now our License only shows one address 1177, but it is for both mailing addresses 1177 and 1173." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 100			

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0 250	Continued From page 4	0 250		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department;	0 250		

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0 250	Continued From page 5 (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 250			

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0 250	Continued From page 6 The findings include: On August 28, 2023, at approximately 11:22 a.m., licensed assisted living director (LALD)-A stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities.	0 250			

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0 250	Continued From page 7 - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or	0 250			

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0 250	Continued From page 8 subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page three was electronically signed by quality improvement director (QID)-F on December 14, 2022. The licensee had an assisted living license issued on January 1, 2023, with an expiration date of December 31, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - implementation of the assisted living bill of rights; - conducting appropriate screenings, or	0 250			

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0 250	Continued From page 9 documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management; and - delegation of tasks by registered nurses or licensed health professionals. On August 31, 2023, at 9:17 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided Assisted living services but failed to develop and implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued 0100, 0250, 0430, 0470, 0480, 0580, 0640, 0680, 0790, 0800, 0810, 0830, 0900, 1060, 1290, 1440, 1470, 1500, 1750, 1790, 2240, 2290, 2310, and 3090 indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted	0 430			

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0 430	Continued From page 10 under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a copy of the uniform checklist disclosure of services (UDALSA) with the required content to one of six residents (R1) with records reviewed. 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). The findings include: R1 was admitted to licensee on April 11, 2023. R1's Diagnosis included colon cancer, benign neoplasm of brain, and seizure disorder R1's record lacked a signed acknowledgement of receipt of the licensee's UDALSA.	0 430			

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0 430	Continued From page 11 On August 29, 2023, at 10:19 a.m. licensed assisted living director (LALD)-A stated, "as far as the UDALSA that is a negative, he [R1] was never given it, it appears nobody here was, best we can tell." Licensee's Uniform Checklist policy dated March 25, 2022, indicated that the uniform checklist disclosure of services must be provided to all prospective residents before a contract is executed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:	0 470		

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0 470	Continued From page 12 (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to ensure the staffing plan was posted for residents, staff, and visitors to review as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 28, 2023, at 10:30 a.m., the surveyor did not observe a posted staff schedule in any area of the facility developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff	0 470			

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0 470	Continued From page 13 member's resident assignments, at the beginning of each work shift in a central location. On August 28, 2023, at 12:47 p.m., the surveyor asked to see the posted staffing schedule. Unlicensed personnel (ULP)-C stated, "We do not have one posted." On August 28, 2023, at 1:45 p.m., licensed assisted living director (LALD)-A stated, "They [corporate] do not do a staffing schedule printed for this house, I am just going to honest. We are missing most of the postings, so we are working on getting those completed." The licensee's Direct Care Staffing Plan policy dated May 9, 2023, read, "the clinical nurse manager will develop a 24-hour daily staffing schedule. The 24-hour daily staffing schedule will include; a. Direct-care staff work schedules for each direct-care staff member; b. Indication of all work shifts, including days and hours word; c. Identify direct-care staff member's resident assignments or work locations; d. The posted daily work schedule will not include direct-care staff members' resident assignments. The daily work schedule will be posted in a central location in each building of the facility accessible to staff, residents, volunteers, and the public." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470			

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0 480	Continued From page 14	0 480			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated August 28, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant	0 580			

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0 580	Continued From page 15 to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program (QMP) appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 28, 2023, at 11:25 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated, "We have not yet started the QAPI meetings, it is on our list of things to do but there has not been one done for here [HFID 34994]."	0 580			

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0 580	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 640			

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0 640	Continued From page 17 a large portion or all of the residents). The findings include: On August 28, 2023, at approximately 10:30 a.m., the surveyor observed a cordless phone and charger in two of the living room common areas. The surveyor observed the facility's main entry area and common areas lacked the required posted information as follows: - posting of 911 emergency number in common areas and near telephones provided by the Assisted Living facility. On August 28, 2023, at 1:45 p.m., licensed assisted living director (LALD)-A stated, "We are missing most of the postings, so we are working on getting those completed." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	0 680		

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0 680	Continued From page 18 and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - Annual review of the EPP; - Quarterly review of missing resident policy; - Policies and procedures for maintaining	0 680		

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0 680	Continued From page 19 independence, communication, transportation, supervision and medical care; - Policies and procedures for cooperation and collaboration with local, tribal, State and Federal EP to maintain integrated response; - Policies and procedures for subsistence needs for staff and residents; - Policies and procedures for sheltering in place; - Policies and procedures for volunteers; - Arrangements with other facilities; - Roles under wavier declared by secretary; - Development of Communication Plan; - Emergency officials contact information; - Methods for sharing information; - Sharing information on Occupancy/Needs and - Emergency prep testing requirements. On August 31, 2023, at 9:05 a.m., licensed assisted living director (LALD)-A stated that to the best of their knowledge, the provided emergency preparedness plan (EPP) was complete. LALD-A stated that there was no additional information to add. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code,	0 790		

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0 790	Continued From page 20 located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On August 29, 2023, between 10:30 a.m. and 12:10 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed that portable fire extinguishers were stored on the floor. Fire extinguishers must be properly mounted to prevent them from being moved or damaged. The fire extinguishers in the garage did not have service tags or labels attached. Fire extinguishers need to be maintained annually by certified personnel so that they can be used reliably and effectively in an emergency. These deficient conditions were verified by LALD-A accompanying on the facility tour.	0 790			

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0 790	Continued From page 21	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 29, 2023, between 10:30 a.m. and 12:10 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During	0 800			

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0 800	Continued From page 22 the facility tour, survey staff observed the following: 1. Survey staff requested records for the most recent inspection of the automatic fire alarm system. Documentation was not provided showing that the system was compliant. No further information was provided. 2. Exit signs were not posted at the doors designated as emergency exits on the floor plans posted in the facility. 3. Emergency exits were shown on the floor plans directing occupants to exit the building through the garages for sides A and B. Exits are required to lead directly to the exterior of the building and not through a higher hazard room. 4. In resident shared bathrooms: a. At the junction of the wall and floor, chipped tiles with rough edges were observed in two of the bathrooms. b. Cracked floor tiles were observed in the bathroom on side B for resident rooms 3 and 4. c. Caulk was missing between the base of the toilets and the floor in several of the bathrooms. 5. Electrical panels were obstructed in both garages. 6. Burnt used cigarettes were observed being disposed of in a tin can on a table in the garage of side B, creating a potential fire hazard. The LALD-A explained that listed disposal containers for cigarettes should be used. 7. The self-closing latch for the garage fire door was not working properly on side B. 8. In the nursing office, two power strips were daisy-chained together, creating a fire hazard. 9. In resident room 3 on side A, the refrigerator was plugged into a multi-plug outlet adapter. Additionally, a power strip was plugged into a multi-plug outlet adapter. This improper use of multi-plug outlet adapters and power strips was	0 800			

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0 800	Continued From page 23 creating a fire hazard. 10. The doorknob was missing on the interior side of the door for the fire sprinkler riser room. 11. Metal exterior door trim had become detached in several locations with sharp edges exposed on both front doors. These deficient conditions were verified by LALD-A accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to	0 810		

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0 810	Continued From page 24 include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop fire safety and evacuation plans with the required elements; failed to provide the required employee training on fire safety and evacuation; failed to provide training to residents capable of assisting in their own evacuation; and failed to complete the required employee evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 29, 2023, between 10:30 a.m. and 12:10 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed that the location of resident sleeping rooms on the posted floor plans did not match. The floor plans posted	0 810			

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0 810	Continued From page 25 at the back exits identified resident sleeping rooms as 1-8. The floor plans posted at the front doors identified resident sleeping rooms as 1-4. Additionally, one of the floor plans showed a service door between the two garages, which was not accurate. On August 29, 2023, at approximately 12:10 p.m., records were provided for review. 1. Record review of the available documentation indicated that the fire safety and evacuation plans had not been developed and maintained for the facility location. The fire plans in the emergency preparedness binder reference stairs, pull fire alarms, and door magnets, which were not observed during the facility tour. 2. The fire plans in the emergency folder did not include procedures for resident relocation during a fire or similar emergency. 2. Record review of the available documentation indicated that there was not a policy for employee training on the facility fire safety and evacuation plans. Records were not provided to support that employee training on the facility fire safety and evacuation plans had been completed. The employee training frequency requirement of upon hiring and at least twice per year thereafter was not met. 3. Record review of the available documentation indicated that there was not a policy for resident training on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. Records were not provided to support that resident training had been completed. Fire safety and evacuation training was not made available to residents at least once per year.	0 810			

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0 810	Continued From page 26 4. Record review of the available documentation indicated that there was not a policy on evacuation drills. Evacuation drill records were requested by survey staff but not provided. The evacuation drill frequency requirement of twice per year per shift with at least one evacuation drill every other month was not met. On August 29, 2023, at approximately 1:10 p.m., the clinical nurse supervisor (CNS)-B verified these deficient conditions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 830 SS=I	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable state and local laws, regulations, standards, ordinances, and codes related to smoking for three of six residents (R2, R4, R5). 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 serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 830	On August 30, 2023, the immediacy of correction order 0830 was removed, however non-compliance remained at a level three, widespread violation.	

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0 830	Continued From page 27 has affected or has the potential to affect a large portion or all of the residents). This practice resulted in an immediate correction order on August 29, 2023, at approximately 12:15 p.m. The findings include: On August 29, 2023, at 6:45 a.m., the surveyor observed R2 sitting in the side B attached garage (house number 1173) smoking a cigarette. R2 R2 admitted to the facility on March 11, 2011. R2's diagnoses included diabetes, hypertension, and catheter dependence. R2's Service Recap Summary dated August 1, 2023, through August 31, 2023, indicated R2 received daily light housekeeping, weekly deep room cleaning, and safety checks five times a day. R2's last clinical update assessment dated July 24, 2023, indicated under smoking assessment, that R2 had the ability to safely light, smoke, and extinguish cigarettes in the garage, and no interventions were added. R4 R4 admitted to the facility on March 19, 2022. R4's diagnoses included diabetes, epilepsy, and hemiplegia. R4's Service Recap Summary dated August 1, 2023, through August 31, 2023, indicated R4 received weekly deep room cleaning, weekly	0 830			

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0 830	Continued From page 28 linen change, monthly vitals, monthly medication set up, and safety checks five times a day. R4's last clinical update assessment dated July 19, 2023, indicated under smoking assessment, that R4 smoked in the garage, and kept smoking materials in R4's room, and no interventions were added. R5 R5 admitted to the facility on August 10, 2016. R5's diagnoses included spinal cord injury and depression. R5's Service Recap Summary dated August 1, 2023, through August 31, 2023, indicated R5 received weekly deep room cleaning, AM/PM dressing, twice daily light housekeeping, monthly vitals, and safety checks five times a day. R5's last clinical update assessment dated July 24, 2023, indicated under smoking assessment, that R5 smokes one pack in four days and holds his cigarette in his mouth without removing it and ashes drop on his clothes. The assessment indicated R5 was offered a smoke apron to protect clothing but declined to use it and R5 puts the lit cigarette in the ashtray unextinguished at times. The assessment indicated staff were to monitor the ashtray for unextinguished cigarette and put them out when needed and staff clean out the ashtray several times a week, so it does not get overly full. During observation on August 29, 2023, at 8:10 a.m., the surveyor observed the side A attached garage (house number 1177) contained a battery-operated power chair, a twin sized box spring, multiple rolls of toilet paper and other	0 830			

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0 830	Continued From page 29 paper products and supplies, as well as miscellaneous furniture and stored items. The side B attached garage (house number 1173) contained two chairs and a folding table with an ashtray on it. Behind the wooden chair next to the folding table was a propane tank with an unknown amount of propane in it. Also located in the garage was a wooden bed frame, an artificial tree boxed up, garbage receptacles, battery-operated motorized scooter, as well as miscellaneous furniture and other stored items. The layout of the facility was a side-by-side duplex style residential home with a connecting hallway in-between. The two attached garages also had a shared wall. There were no fire extinguishers located in either garage. On August 29, 2023, at 8:10 a.m., unlicensed personnel (ULP)-C stated, "There are three guys [residents] here that smoke, they smoke in the garages, but the big garage door is always left open even in the wintertime. We [staff] go out there and empty the ash trays throughout the week." On August 29, 2023, at 8:56 a.m., licensed assisted living director (LALD)-A verified she was aware the residents smoked in the garages, though LALD-A was unaware if there were fire extinguishers located in the garage and indicated ULP-C would know if there was a fire extinguisher located in the garage. ULP-C who was also present stated, "I don't think there is a fire extinguisher out in the garage. At least I have never seen one." The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited indoors of all public places to include	0 830			

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0 830	Continued From page 30 health care facilities and clinics. MCIIA defined "Indoor Area" to be "a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows (open or closed) around the perimeter. A wall includes retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier. A (standard) window screen is not a wall." Minnesota state statute 144.414 Prohibitions; Subdivision 3 dated 2022, indicated under a section titled Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility, except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	0 830			
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable.	0 900			

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0 900	Continued From page 31 (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a written contract with the required content post implementation of 144G Statutes for one of one resident (R2) 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 900			

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0 900	Continued From page 32 The licensee converted to an Assisted Living Facility license on August 1, 2021. R2 admitted to the facility on March 11, 2011. R2's diagnoses included diabetes, hypertension, and catheter dependence. R2's Service Recap Summary dated August 1, 2023, through August 31, 2023, indicated R2 received daily light housekeeping, weekly deep room cleaning, and safety checks five times a day. R2's record lacked a signed contract previous to the Assisted Living Facility license on August 1, 2021, or a signed contract from after the licensee converted to an Assisted Living Facility license on August 1, 2021. On August 29, 2023, at 1:05 p.m., clinical nurse supervisor (CNS)-B stated, "Only two residents have signed contracts the rest of the residents don't have one." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (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. (b) In the event of an emergency relocation, the	01060			

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01060	Continued From page 33 facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (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 (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. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (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. (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 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the	01060			

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01060	Continued From page 34 required content for an emergency relocation to the resident, legal representative, or designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days, for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 admitted to the licensee on April 11, 2023. R1's diagnosis included colon cancer, benign neoplasm of brain, and seizure disorder. R1's progress notes dated May 22, 2023, indicated R1 was transferred to the hospital on May 15, 2023, due to gastroenteritis. R1 returned to the licensee on May 20, 2023. R1's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. The record also lacked evidence to indicate the licensee provided the notification to the OOLTC of the emergency relocation greater than four days as required. On August 29, 2023, at 1:07 p.m., CNS- stated, "An emergency relocation form? No. We don't	01060			

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01060	Continued From page 35 have those I have never done that. I didn't realize that is what the regulations were meaning. So, I have never done that." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was conducted prior to staff providing services for one of five employees (licensed practical nurse (LPN)-G). In addition, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three of five employees (clinical nurse supervisor (CNS)-B, unlicensed	01290	On August 31, 2023, the immediacy of correction order 1290 was removed, however non-compliance remained at a level three, widespread violation.	

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01290	Continued From page 36 personnel (ULP)-C and ULP-H). 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 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). This practice resulted in an immediate correction order on August 30, 2023, at approximately 1:50 p.m. This correction order was amended to remove licensed assisted living director (LALD)-A from the sample as LALD-A was licensed by the Board of Executives for Long Term Services and Supports after 2018. Due to the de-duplication efforts of the Department of Human Services, LALD-A was exempt from being placed on the licensee's NETStudy 2.0 roster. The amendment did not change the scope or level of the correction order. The findings include: On August 28, 2023, from 1:50 p.m. to 2:15 p.m., the surveyor observed LPN-G to be the only staff person working on site with the residents. LPN-G LPN-G began working for another facility under the same ownership umbrella of the licensee on November 1, 1996. LPN-G's employee record included background study clearance letter dated August 29, 2023,	01290			

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01290	Continued From page 37 affiliated to ownership umbrella DHS code 1073083, and completed during the survey process. LPN-G's record lacked evidence the licensee submitted a background study for LPN-G under the current assisted living license and affiliated to the licensee's HFID number prior to the start of the survey. CNS-B CNS-B started working for the licensee on August 8, 2023. CNS-B's employee record included background study clearance letter dated August 7, 2023, affiliated to ownership umbrella HFID 38783 for another facility. CNS-B's record lacked evidence the licensee submitted a background study for CNS-B under the current assisted living license and affiliated to the licensee's HFID number. ULP-C ULP-C started working for the licensee on June 27, 2022. ULP-C's employee record included background study clearance letter dated June 16, 2022, affiliated to ownership umbrella DHS code 1073083. ULP-Cs record lacked evidence the licensee submitted a background study for ULP-C under the current assisted living license and affiliated to the licensee's HFID number. ULP-H ULP-H started working for the licensee on March 16, 2022. ULP-H's employee record included background study clearance letter dated August 5, 2022, affiliated to ownership umbrella DHS code 1073083. ULP-H's record lacked evidence the	01290			

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01290	Continued From page 38 licensee submitted a background study for ULP-H under the current assisted living license and affiliated to the licensee's HFID number. On August 30, 2023, at 8:43 a.m., licensed assisted living director (LALD)-A stated, "They [licensee] can't find [LPN-G's] original background study, she [LPN-G] thinks she herself may have her original form that she thinks is from 2004 when they first started doing background studies, I asked her to look for it and get it to me if she has it. They are running the background checks under an umbrella system so that number you saw [1073083] is affiliated with the [licensee] but not running it under this specific HFID." Additionally, LALD-A stated, "The process I can tell you how it is done only based off how they did mine, and that was they interviewed me and then had HR [Human Resources] run a background on me. When I spoke to HR yesterday, if someone pops up in the system for needing to get fingerprinting, they send them for fingerprinting. They looked for [LPN-G's] and they said she has been here for twenty some years, but they looked and it's not able to be found anywhere in the system, so they ran it [background study] for [LPN-G] yesterday." On August 30, 2023, at 9:58 a.m., surveyor inquired if other staff hired prior the implementation of 144G regulations would have had a background study done. LALD-A stated, "I can't honestly answer that questions, I don't know if they went back and ran all the background studies for staff hired prior to 144G." The Licensee's Background Studies policy dated August 1, 2021, read, "All employees; as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will	01290			

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01290	Continued From page 39 undergo a background study through DHS. Only those with satisfactory results will continue to work with the facility and its residents. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the	01440		

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01440	Continued From page 40 registered nurse (RN) completed supervision of unlicensed personnel (ULP) within 30 calendar days of the ULP performing delegated tasks for one of two employees (unlicensed personnel (ULP)-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-H began working for the licensee March 16, 2022, to provide direct care services to residents. ULP-H's record lacked evidence a RN conducted direct supervision of ULP-H within 30 days of performing delegated tasks. On August 31, 2023, at 9:38 a.m., clinical nurse supervisor (CNS)-B indicated that this would be a widespread issue as all staff were trained at a different licensed facility under the same ownership umbrella and then were moved to other facilities with different health facility identification (HFID) numbers. The training included 30-day supervision of delegated tasks. The licensee's Supervision of Unlicensed Staff policy dated November 17, 2022, indicated that direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments, or assigned therapy tasks must be supervised within 30 days after the person begins work for the agency and has been trained and determined	01440			

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01440	Continued From page 41 competent to perform all the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (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; (3) handling of emergencies and use of 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 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	01470			

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01470	Continued From page 42 (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, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: Based on observation, 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 three employees (unlicensed personnel (ULP)-C). 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	01470			

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01470	Continued From page 43 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: ULP-C ULP-C was hired on June 13, 2022, to perform direct care services to the licensee's residents. On August 28, 2023, at 12:23 p.m., the surveyor observed ULP-C provide direct care to R1. ULP-C's employee record lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: -handing of resident complaints, reporting of complaints, where to report; -review of types of assisted living services the employee will provide and provider's scope of license; -principles of person-centered planning/service delivery; and -initial 8 hours of dementia care training. On August 30, 2023, at 11:03 a.m., licensed assisted living director (LALD)-A confirmed that the orientation was not all there and stated, "You were given everything in the employee files and the items that you don't find are items they don't have. I have let them know that everyone needs the eight hours of dementia training with orientation and that is something we will start doing going forward and those that are already here will need to get dementia training completed." The licensee's Orientation to Resident policy, dated August 1, 2021, read, "[licensee] will orient	01470			

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01470	Continued From page 44 each staff person responsible for providing assisted living services to that resident and to the specific services to be provided. This orientation may be provided in person, orally, in writing or electronically." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01500 SS=F	144G.63 Subd. 5 Required annual training (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: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (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 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (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	01500		

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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
01500	Continued From page 45 disease, or related disorders; (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 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-C) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01500			

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01500	Continued From page 46 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on June 13, 2022, to perform direct care services to the licensee's residents. ULP-C's record lacked evidence annual training had been completed as required in the following areas: - review of provider's policies and procedures; - principles of person-centered planning/service delivery; and - two hours dementia training. On August 29, 2023, at 12:55 p.m., clinical nurse supervisor (CNS)-B stated, "nobody has had annual education yet. I planned to do a skills fair in October, but you all being here now will help me to bump that date up to September, then we can get everyone trained at once." The licensee did not produce a policy on annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration	01750			

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01750	Continued From page 47 When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure prior to delegating the task of medication administration, the registered nurse (RN) trained the unlicensed personnel (ULP) in the proper methods to perform the task or procedure for each resident and verified one of two ULP (ULP-H) was able to demonstrate the ability to competently follow the procedure. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-H began working for the licensee March 16, 2022, to provide direct care services to residents.	01750			

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01750	Continued From page 48 ULP-H's record lacked a competency evaluation completed by a RN for medication administration affiliated with the licensee. ULP-H's record contained a medication administration competency from a seperate affiliated facility. On August 31, 2023, at 9:38 a.m., clinical nurse supervisor (CNS)-B indicated that this would be a widespread issue as all staff are trained at a different licensed facility under the same ownership umbella and then were moved to other facilities with different health facility identification (HFID). This training included competency evaluations for medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (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; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (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.	01790			

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01790	Continued From page 49 (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (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 (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: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) 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; (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; (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 (vii) how the unlicensed personnel must document in the resident's record any unused	01790			

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01790	Continued From page 50 medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) documented training and/or competencies for one of two unlicensed personnel ((ULP)-C) who would provide medications for residents with unplanned time away from home when a licensed nurse was not available. 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: ULP-C ULP-C was hired on June 13, 2022, to perform direct care services to the licensee's residents. On August 29, 2023, at 8:13 a.m., surveyor observed ULP-C provide direct care to R1. ULP-C's record lacked documentation they were trained and found competent by the RN to provide medications to residents who may have an unplanned time away from home. On August 30, 2023, at 11:03 a.m. licensed assisted living director (LALD)-A stated, "You	01790			

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01790	Continued From page 51 were given everything in the employee files and the items that you don't find are items they don't have." Surveyor requested a policy, and the licensee produced the licensee's Medication Set Up Competency for Unplanned Time Away dated February 28, 2022, which indicated the steps needed for sending out medications for unplanned times away, though no policy was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
02240 SS=C	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. If you would like to request advocacy services, you may contact	02240			

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02240	Continued From page 52 the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, email address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, email, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written acknowledgement of receipt of the current assisted living bill of rights was obtained for one of one resident (R2). 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	02240		

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02240	Continued From page 53 the residents). The findings include: R2 admitted to the facility on March 11, 2011. R2's diagnoses included diabetes, hypertension, and catheter dependence. R2's Service Recap Summary dated August 1, 2023, through August 31, 2023, indicated R2 received daily light housekeeping, weekly deep room cleaning, and safety checks five times a day. R2's record lacked written acknowledgement that he received the current Minnesota Bill of Rights for Assisted Living Residents, as required. On August 29, 2023, at 12:57 p.m., clinical nurse supervisor (CNS)-B stated, "[R2] has no UDALSA and no bill of rights in his file, this is all we have." On August 29, 2023, at 1:43 p.m., licensed assisted living director (LALD)-A stated, "Nobody has the UDALSA, and nobody has a bill of rights because we don't have them in the three-ring binder and they are not in RTasks [electronic charting system]." The licensee's Assisted Living Bill of Rights policy, dated March 14, 2023, read, "Before receiving services, individuals in our care shall be informed of the rights granted to them and to be aware of recourse if those rights are violated. This information will be made available in plain language in terms that each individual can understand we are responsible for taking reasonable accommodations for individuals who have communication disabilities and to those who	02240			

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02240	Continued From page 54 speak a language other than English. A. Each individual will be provided written notice of rights prior to initiation of services period B. The written notice shall include a statement describing how to file a report of suspected maltreatment. C. Acknowledgement shall be obtained from the resident of receipt of the assisted living Bill of Rights or documentation will be maintained of why the receipt cannot be obtained. This shall be maintained in the persons record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02240			
02290 SS=D	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee limited the rights of one resident (R2) when the licensee removed the resident's bed rail upon discovery without assessment by a registered nurse (RN) and without discussing the risk versus benefit or offering alternatives with the resident and/or the resident's designated representative. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02290			

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02290	Continued From page 55 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On August 28, 2023, at 1:05 p.m., the surveyor observed a bed rail on side of R2's bed. The bed rail appeared to be a consumer bed rail mounted in between box spring and mattress on the upper right side of the bed. The bed rail was in a lowered position and touching the floor with the ability to be raised and lowered. When asked about the use of the bed rail, R2 stated they utilize the bedrails while getting in and out of bed. R2's diagnoses included diabetes, hypertension, and catheter dependence. R2's most recent assessment dated July 24, 2023, indicated that R2 had no assistive devices for their bed. On August 29, 2023, at 12:18 p.m., the surveyor informed the licensee that an immediate order for bed rails would be issued due to missing bed rail assessments. On August 29, at 1:00 p.m., during interview and observation, it was observed by the surveyor that the bed rail was removed from the R2's bed. R2 was away from the facility at an appointment during the removal of the bed rail on their bed and was not consulted. Clinical nurse supervisor (CNS)-B stated that the bed rail had been removed due to an immediate order being issued	02290			

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02290	Continued From page 56 and stated they did not have required components to safely mount the bed rail to bed. Upon return to facility, the surveyor overheard R2 loudly complaining about the removal of their bed rail. On August 29, 2023, at 1:56 p.m., CNS-B provided an assessment by email to the surveyor indicating that R2's bed rail had been reattached to bed. The licensee's Side Rails policy, dated March 25, 2022, indicated the following will be completed by an RN: - When siderails are in use, the RN conducts an assessment to identify the intended purpose of the siderail and the risks regarding the use of the siderail. - Manufacturer instructions for installation are available and followed. - If the siderail is acting as a restraint, appropriate action should be taken to educate residents, staff, and families, if appropriate, that this is not an acceptable use for siderails. - A review of risks and consent to use a siderail needs to be in place for use. Refusal to remove devices or sign consent must be documented. The licensee's Assisted Living Bill of Rights policy dated March 14, 2023, indicated that residents have the right to actively participate in the planning, modification, and evaluation of their care and services. This right includes: -the opportunity to discuss care, services, treatment, and alternatives with the appropriate caregivers; -the right to include the resident's legal and designated representatives and persons of the resident's choosing; and -the right to be told in advance of, and take an	02290		

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02290	Continued From page 57 active part in decisions regarding, any recommended changes in the service plan. Per Minnesota State Statute 144G. 91: Subd. 5 Refusal of care or services. Residents have the right to refuse care or assisted living services and to be informed by the facility of the medical, health-related, or psychological consequences of refusing care or services; Subd. 6 Participation in care and service planning. Residents have the right to actively participate in the planning, modification, and evaluation of their care and services. This right includes: (1) the opportunity to discuss care, services, treatment, and alternatives with the appropriate caregivers; (2) the right to include the resident's legal and designated representatives and persons of the resident's choosing; and (3) the right to be told in advance of, and take an active part in decisions regarding, any recommended changes in the service plan; and Subd. 16 Right to furnish and decorate. Residents have the right to furnish and decorate the resident's unit within the terms of the assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02290			
02310 SS=G	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the	02310			

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02310	Continued From page 58 resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of four residents (R2) with bed rails. 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 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). This practice resulted in an immediate correction order on August 29, 2023, at approximately 1:15 p.m. The findings include: On August 28, 2023, at 1:05 p.m., the surveyor observed a bed rail on side of R2's bed. The bed rail appeared to be a consumer bed rail mounted in between box spring and mattress on the upper right side of the bed. The bed rail was in a lowered position and touching the floor with the ability to be raised and lowered. The bed rail was not securely attached to bed and was able to be moved out from between the box spring and mattress with minimal effort. When asked about the use of the bed rail, R2 stated they utilize the bedrails while getting in and out of bed.	02310	On August 30, 2023, the immediacy of correction order 2310 was removed, however non-compliance remained at a level three, isolated violation.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/31/2023
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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
02310	Continued From page 59 R2's diagnoses included diabetes, hypertension, and catheter dependence. R2's most recent assessment dated July 24, 2023, indicated that R2 had no assistive devices for their bed. R2's record lacked: -Purpose and intention of the bed rail; -Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; -The resident's bed rail use/need assessment; -Risk vs. benefits discussion (individualized to each resident's risks); -The resident's preferences; -Installation and use according to manufacturer's guidelines; -Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; -Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; and -Evidence the licensee referred to the Consumer Product Safety Commission (CPSC) for the most up-to-date information related to portable bed rail recall information. On August 29, 2023, at 9:57 a.m., licensed assisted living director (LALD)-A stated, "I am going to be honest with you, I spoke to the clinical nurse supervisor (CNS)-B and she said if the July 24, 2023, assessment stated no bed rail then we own that because there should be an assessment in Rtasks [an electronic charting system] for it and there is not one." The licensee's Side Rails policy, dated March 25,	02310		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER CREEKSIDE VILLAS		STREET ADDRESS, CITY, STATE, ZIP CODE 1177 117TH AVENUE COON RAPIDS, MN 55448			
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02310	Continued From page 60 2022, indicated the following assessments will be completed by an RN: - When siderails are in use, the RN conducts an assessment to identify the intended purpose of the siderail and the risks regarding the use of the siderail. - Manufacturer instructions for installation are available and followed. - If the siderail is acting as a restraint, appropriate action should be taken to educate residents, staff, and families, if appropriate, that this is not an acceptable use for siderails. - A review of risks and consent to use a siderail needs to be in place for use. Refusal to remove devices or sign consent must be documented. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated 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." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls.	02310			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER CREEKSIDE VILLAS		STREET ADDRESS, CITY, STATE, ZIP CODE 1177 117TH AVENUE COON RAPIDS, MN 55448			
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02310	Continued From page 61 This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". In addition, the MDH website indicated, "licensees should refer to the CSPC for the most up-to-date information related to portable bed side rail recall information." No further information provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/31/2023
NAME OF PROVIDER OR SUPPLIER CREEKSIDE VILLAS		STREET ADDRESS, CITY, STATE, ZIP CODE 1177 117TH AVENUE COON RAPIDS, MN 55448			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
03090	Continued From page 62 cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all six residents, staff and visitors to the facility. 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). The findings include: On August 28, 2023, at approximately 12:47 p.m., the surveyor observed no electronic monitoring notice posted in the facility with the statutory required language. On August 28, 2023, at 1:45 p.m., licensed assisted living director (LALD)-A stated, "We are missing most of the postings, so we are working on getting those completed." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/31/2023
NAME OF PROVIDER OR SUPPLIER CREEKSIDE VILLAS		STREET ADDRESS, CITY, STATE, ZIP CODE 1177 117TH AVENUE COON RAPIDS, MN 55448			
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Type: Full
Date: 08/28/23
Time: 11:00:00
Report: 1031231215

Food and Beverage Establishment Inspection Report

Page 1

Location:

Creekside Villas
1177 117th Avenue
Coon Rapids, MN55448
Anoka County, 02

Establishment Info:

ID #: 0037773
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637546899
ID #:

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

The following orders were issued during this inspection.

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

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

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

OBSERVED RAW EGGS STORED ABOVE MILK AND JUICE IN KITCHEN A REFRIGERATOR. HAD STAFF MOVE EGGS DOWN AND AWAY.

Comply By: 08/28/23

3-700 Contaminated Food: discarded

3-701.11A ** Priority 1 **

MN Rule 4626.0445A Discard or recondition food that is unsafe, adulterated or not honestly presented.

HAM STORED IN KITCHEN B REFRIGERATOR HAS SIGNS OF SPOILAGE. ***ITEM DISCARDED***
CHECK DATE ALL FOODS FOR SIGNS OF SPOILAGE AND MAINTAIN DATE MARKING SYSTEM.

Comply By: 08/28/23

7-200 Toxic Supplies and Applications

7-201.11A ** Priority 1 **

MN Rule 4626.1600A Separate poisonous or toxic materials from food, equipment, utensils, linens, and single-service and single-use articles by spacing or partitioning.

SOAP AND SANITIZER FOUND STORED NEXT TO AND ABOVE FOOD PRODUCTS. HAD STAFF MOVE SOAP AND SANITIZER TO SINK AREA. STORE ALL CHEMICALS AS DIRECTED ABOVE.

Comply By: 08/28/23

Type: Full
Date: 08/28/23
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Report: 1031231215
Creekside Villas

Food and Beverage Establishment Inspection Report

Page 2

3-500C Microbial Control: date marking

3-501.17A **** Priority 2 ****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared 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.

HAM STORED IN KITCHEN B REFRIGERATOR NOT DATE MARKED. FOLLOW ABOVE RULE.

Comply By: 08/28/23

2-100 Supervision

2-102.12AMN

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

ESTABLISHMENT DOES NOT HAVE A CERTIFIED FOOD PROTECTION MANAGER (CFPM). PIC IN PROCESS OF COMPLETING CLASS.

Comply By: 08/28/23

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

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

MULTIPLE FOOD ITEMS STORED ON FLOOR OF KITCHEN B. STORE ALL FOOD ITEMS AS DIRECTED ABOVE.

Comply By: 08/30/23

4-600 Cleaning Equipment and Utensils

4-601.11B

MN Rule 4626.0840B Maintain the food contact surfaces of cooking equipment and pans free of encrusted grease deposits and other soil accumulations.

STOVE IN KITCHEN B FOUND WITH ENCRUSTED FOOD DEBRIS THROUGHOUT CAVITY. CLEAN AND MAINTAIN CLEAN.

Comply By: 09/11/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.114AB

MN Rule 4626.1580AB Remove all items unnecessary to the operation or maintenance of the establishment and litter from the premises.

BOTH KITCHENS HAVE MULTIPLE ITEMS ON COUNTERS NOT REQUIRED FOR OPERATION OF ESTABLISHMENT. REMOVE ALL ITEMS NOT NEEDED FROM COUNTERS.

Comply By: 09/05/23

Food and Equipment Temperatures

Process/Item: Cold Hold/Rice

Temperature: 40 Degrees Fahrenheit - Location: Refrigerator (kitchen A)

Violation Issued: No

Type: Full
Date: 08/28/23
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Creekside Villas

Food and Beverage Establishment Inspection Report

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Process/Item: Cold Hold/Pasta
Temperature: 41 Degrees Fahrenheit - Location: Refrigerator (kitchen B)
Violation Issued: No

Process/Item: Delivery/Hot Dogs
Temperature: 184 Degrees Fahrenheit - Location: Thermal Transport Pack
Violation Issued: No

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		3	1	4

Inspection conducted by Chris F (MDH).

All violations discussed with Jody after inspection.

Discussed:

- Illness and illness log
- Facilities upkeep and maintenance
- Handwashing and glove use

Notes:

Left sink basin designated for handwashing.
Dishwasher is NSF (kitchen A) and UL (kitchen B) certified.
Pasteurized eggs used
All cooking of meats done at Camilla Rose Kitchen

NOTIFY INSPECTOR OF ADDITIONS OR CHANGES TO THE BUILDING, MAJOR EQUIPMENT ADDITIONS, OR CHANGES OF EQUIPMENT DUE TO A MENU CHANGE. THESE ACTIONS MAY REQUIRE A REMODEL PLAN REVIEW.

***ANY CUSTOMER COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

Type: Full
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Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Environmental Health inspection report number 1031231215 of 08/28/23.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Jody Mason
Person in Charge

Signed: _____

Chris Foster
Public Health Sanitarian II
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031231215		Food Establishment Inspection Report						
	Environmental Health Food, Pools, and Lodging 625 Robert St. N St. Paul		No. of RF/PHI Categories Out		4	Date 08/28/23		
			No. of Repeat RF/PHI Categories Out		0			
			Legal Authority MN Rules Chapter 4626					
Creekside Villas		Address 1177 117th Avenue		City/State Coon Rapids, MN		Zip Code 55448	Telephone 7637546899	
License/Permit # 0037773		Permit Holder		Purpose of Inspection Full		Est Type		Risk Category
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS								
Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item								
Mark "X" in appropriate box for COS and/or R								
IN= in compliance OUT= not in compliance N/O= not observed N/A= not applicable COS=corrected on-site during inspection R= repeat violation								
Compliance Status				COS		R		
Supervision								
1	IN	OUT	PIC knowledgeable; duties & oversight					
2	IN	OUT	N/A	Certified food protection manager, duties				
Employee Health								
3	IN	OUT	Mgmt/Staff;knowledge,responsibilities&reporting					
4	IN	OUT	Proper use of reporting, restriction & exclusion					
5	IN	OUT	Procedures for responding to vomiting & diarrheal events					
Good Hygienic 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			
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 labeled; original container				
Prevention of Food Contamination								
38				Insects, rodents, & animals not present				
39	X			Contamination prevented during food prep, storage & display				
40				Personal cleanliness				
41				Wiping cloths: properly used & stored				
42				Washing fruits & vegetables				
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	X			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	X			Physical facilities installed, maintained, & clean				
56				Adequate ventilation & lighting; designated areas used				
57				Compliance with MCIAA				
58				Compliance with licensing & plan review				
Food Recalls:								
Person in Charge (Signature)								
Date: 08/28/23								
Inspector (Signature)								