Electronically Delivered

February 10, 2025

Licensee
Cascade Creek Memory Care
3530 Fairway Ridge Lane Southwest
Rochester, MN 55902

RE: Project Number(s) SL37785016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 19, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37785	A. BUILDING: _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE CREEK MEMORY CARE	3530 FAIRWAY RIDGE LANE SW ROCHESTER, MN 55902

(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 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: SL37785016-0 On December 16, 2024, through December 19, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 45 residents; 45 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for three of three residents (R1, R2, R3). 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 R1 began receiving assisted living with dementia care (ALFDC) services from the licensee on December 4, 2023. R1's diagnoses included dementia, type 2 diabetes with insulin dependence, and	0 630		

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0 630	Continued From page 2 depression. R1's Service Plan dated December 13, 2024, indicated he received services including medication administration, blood sugar monitoring, assistance with grooming, bathing, and dressing, and behavior management. On December 17, 2024, at 7:03 a.m., unlicensed personnel (ULP)-I was observed to check R1's blood sugar and blood pressure. R1's IAPP dated November 14, 2024, included the following areas of vulnerability: -not oriented to person, place, time, labeled "true" and included the following intervention-staff to provide cues and reminders. Staff to monitor; -unable to manage finances-labeled "true", with the intervention, "family manages"; -is resident susceptible to abuse from another individual including other vulnerable adults, with the selection "false"; and -resident has some identified areas of potential vulnerabilities but there are no signs of abuse. R2 R2 began receiving ALFDC services from the licensee on November 20, 2023. R2's diagnoses included Lewy Body dementia, unspecified Parkinsonism, and anxiety disorder. R2's Service Plan dated October 22, 2024, indicated she received services including medication administration, assistance with bathing, dressing, transfers and ambulation, hospice services, and urinary catheter care. On December 16, 2024, at 2:25 p.m., the surveyor observed ULP-H empty R2's urinary	0 630		

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0 630	Continued From page 3 catheter bag. R2's IAPP dated November 20, 2024, included the following: -resident has chronic conditions, pain, illness, disability, with the selection A. True, and with interventions listed as A. Resident will have regular follow up with physicians regarding chronic conditions B. Resident will take prescribed medications as directed C. Staff to notify nurse promptly for any changes in condition; -unable to manage finances A. Ture [sic] Describe Vulnerability: family manages finances with Approach/Intervention-A. Responsible party manages finances; -is resident susceptible to abuse from another individual, including other vulnerable adults? B. False; and -resident has some identified areas of potential vulnerability, but there are no signs of abuse or neglect; R3 R3 began receiving ALFDC services from the licensee on September 12, 2024. R3's diagnoses included dementia and history of deep vein thrombosis (blood clots) of right lower extremity. R3's Service Plan dated October 9, 2024, indicated she received services including medication administration, assistance with bathing, compressing stockings, and transfers. On December 17, 2024, at 6:45 a.m., ULP-I was observed donning (putting on) R3's compression stockings.	0 630		

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0 630	Continued From page 4 R3's IAPP dated November 12, 2024, included the following: -Unable to manage finances A. Ture [sic], with the interventions as A. Responsible party manages finances, B. Power of attorney manages finances; -unable to report abuse/ neglect/exploitation. A. True with interventions as A. Staff to monitor for signs or symptoms of abuse/ neglect/exploitation and report to nurse promptly; -is resident susceptible to abuse from another individual, including other vulnerable adults? B. False; and -resident does not appear to have any areas of vulnerability requiring interventions at this time. The licensee failed to accurately depict R1, R2, and R3's risk for abuse by others including other vulnerable adults; furthermore, the licensee failed to include additional interventions to mitigate their risk for abuse. On December 18, 2024, at 2:15 p.m., clinical nurse supervisor (CNS)-B stated all residents are considered vulnerable adults and would all be susceptible to abuse by others. CNS-B further stated the licensee would address each resident's IAPP appropriately moving forward. The licensee's Individual Abuse Prevention Plan policy dated July 31, 2021, indicated [licensee name] will develop and implement an individual abuse prevention plan for each vulnerable adult. All residents in an assisted living are categorically considered vulnerable adults. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults No further information was provided.	0 630		

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0 630	Continued From page 5 TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of two employees (unlicensed personnel (ULP)-H, ULP-I).	0 650		

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0 650	Continued From page 6 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 ULP-H started employment on October 21, 2024, to provide direct care services to the licensee's residents. On December 16, 2024, at 2:25 p.m. the surveyor observed ULP-H empty R2's urinary catheter bag. ULP-H's employee record lacked the following required content of orientation: -overview of Assisted Living statutes; -handling resident complaints, reporting of complaints, where to report; -consumer advocacy services; and -review of types of Assisted Living services the employee will provide and the provider's scope of license On December 19, 2024, at 9:20 a.m., assisted living director in residency (ALDIR)-A stated the licensee had transitioned to a different employee training program within the past year and the above listed topics were covered in a live class. ALDIR-A further stated the licensee lacked a formal tracking/documentation record with these topics for employee files, stating this would need to be rectified for all recently hired employees.	0 650		

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0 650	Continued From page 7 ULP-I ULP-I started employment on April 4, 2023, to provide direct care services to the licensee's residents. On December 17, 2024, at 7:15 a.m., the surveyor observed ULP-I set up and administer R2's medications. ULP-I stated she was hired as a medication "passer" and received training by the licensee's registered nurse (RN) during orientation. ULP-I further stated she was observed passing medications by the RN. ULP-I's employee record lacked evidence she received training and was deemed competent by the RN with medication administration. On December 19, 2024, at 10:10 a.m., ALDIR-A stated the licensee had several changes over the course of the past year and a half with both leadership and how the licensee managed training. ALDIR-A further stated she was unable to locate ULP-I's medication training/competency as completed by the previous RN. The licensee's Employee Records policy dated July 31, 2021, indicated employee records for each person will include: -Records of all training and in-service education required and/or provided including record of competency testing as required No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 8 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: TB PREVENTION PROGRAM	0 660		

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0 660	Continued From page 9 On December 16, 2024, at 11:30 a.m., the surveyor requested the licensee's TB Risk Assessment. On December 17, 2024, at 8:40 a.m., the surveyor received the licensee's TB Risk Assessment Worksheet for Health Care settings and was dated December 16, 2024 (the day survey began). The TB Risk Assessment indicated the licensee was a low-risk health care setting. On December 17, 2024, at 9:45 a.m., assisted living director in residency (ALDIR)-A stated the TB risk assessment had not been completed until December 16, 2024. She stated the licensee has since created a reminder "tickler" to stay on top of the annual requirement. ALDIR-A further stated the TB risk assessment was last completed in August 2023. The licensee's Tuberculosis Screening Policy dated September 2021, indicated the Community will establish and maintain a comprehensive tuberculosis (TB) control program according to the most current TB infection control guidelines issues by the CDC. The program includes a TB infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The Community will maintain a current community TB risk assessment. The assessment will be updated annually, using data and form provided by the Minnesota Department of Health. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 730	Continued From page 10	0 730		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730		

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0 730	Continued From page 11 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R4 began receiving ALFDC services from the licensee on November 1, 2023. R4 discharged on July 1, 2024. R4's progress note dated July 1, 2024, indicated resident discharge with family to [assisted living facility name]. R4's record lacked a discharge summary to include the following required content: - diagnoses;	0 730		

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0 730	Continued From page 12 - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On December 18, 2024, at 2:10 p.m., clinical nurse supervisor (CNS)-B stated the licensee had no current process for resident discharge summaries, and the required content was not included for R4. The licensee's Contract Termination policy dated July 31, 2021, included a section that read: - at the time of discharge [licensee name] will provide the resident and with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that includes: - a summary of the resident's stay that includes diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results - a final summary of the resident's status from the latest assessment or review, if applicable, which includes the resident status, including baseline and current mental, behavioral, and functional status -a reconciliation of all predischarge medications with the resident's post-discharge prescribed and over-the-counter medications, - a post-discharge care plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post-discharge care plan will indicate where the	0 730		

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	37785	A. BUILDING: _____ B. WING _____	12/19/2024

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0 730	Continued From page 13 resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post-discharge medical and nonmedical services the resident will need. Additionally, the policy indicated: -with the resident's consent, the facility will provide the following information in writing to the resident's receiving facility or other service provider: -the name and address of the facility -the dates of the resident's admission and discharge - the name and address of a person at the facility to contact for additional information - names and addresses of any significant social or community contacts the resident has identified to the facility - the resident's most recent service or care plan, if the resident has received services from the facility; and - the resident's current "do not resuscitate" order and "physician order for life sustaining treatment," if any. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;	0 780		

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0 780	Continued From page 14 (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to comply with Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly 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) 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 December 18, 2024, at 9:10 a.m., the surveyor toured the facility with assisted living director in residency (LALDIR)-A and	0 780		

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0 780	Continued From page 15 environmental services director (ESD)-K. During the tour, the surveyor observed electromagnetic locks were installed on the emergency exit doors on the second floor. A switch to break the power for the egress control locking system was not installed for these doors. During the facility tour interview on December 18, 2024, LALDIR-A verified the above listed observation. On December 20, 2024, an email was received by LALDIR-A. The email included additional information on the egress control locking system. In the email, LALDIR-A explained the controlled locking system for the main entrance can be unlocked using a switch that directly breaks power installed at the front station. The two exit doors leading to the stairwell on the second floor can be unlocked at the nurse station with a signal from the computer. The entire egress control locking system shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock. Egress control locking systems must comply with Minnesota State Fire Code Rules, Chapter 7511 for the entire locking system. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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;	0 810		

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0 810	Continued From page 16 (2) staff 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) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide the required training and drills. This had the potential to directly 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 810		

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0 810	Continued From page 17 or has potential to affect a large portion or all of the residents). The findings include: On December 18, 2024, assisted living director in residency (LALDIR)-A and environmental services director (ESD)-K provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year after hire evident by the lack of training documentation. During an interview on December 18, 2024, at 11:10 a.m., LALDIR-A stated employees were trained during drills and verified FSEP training records were not available to support this had been completed. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of completed drill reports. In 2024, six evacuation drills were completed. These drills were completed in March, August, September, November, and December. No evacuation drill records were provided for 2023. The names of the employees who participated in the November 2024 fire drill were not recorded on the report. During an interview on December 18, 2024, at 11:10 a.m., LALDIR-A verified the employee evacuation drill frequency was not met and that no evacuation drill records were available prior to March 2024. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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01060	Continued From page 18	01060		
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 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	01060		

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01060	Continued From page 19 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 required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R2). 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: R2 began receiving ALFDC services from the licensee on November 20, 2023. R2's Service Plan dated October 22, 2024, indicated services included medication administration, assistance with bathing, dressing, transfers and ambulation, hospice services, and urinary catheter care. On December 16, 2024, at 2:25 p.m., the surveyor observed unlicensed personnel (ULP)-H empty R2's urinary catheter bag.	01060		

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01060	Continued From page 20 R2's progress notes included: -October 8, 2024, unwitnessed fall with a head strike. Resident was found on the floor when staff went to let her know it was time for breakfast. Resident is fully dressed including shoes. She is only able to respond to questions with a yes or no intermittently. She does have a significant mass on the posterior right lateral proximal portion of her head. While assisting EMS [emergency medical services] to get resident on a sling to lift her to the gurney EMS did a palpation check of her spine. She did vocalize discomfort in the scapular region of her spine. This may be from resident laying on the floor waiting for EMS. Spouse was contacted ASAP, and he has had two messages. Resident is transported to [hospital name] for evaluation. Resident was admitted to the hospital. -October 11, 2024, the resident returned to the facility with her spouse at 3:57 p.m. -November 14, 2024, nursing was contacted with concerns about resident's condition. Staff was asked to contact spouse to see if he would like her sent to the ER. When nursing arrived in the room resident was on the floor and EMS was on the phone. Resident is not responding to sternal rub. Unable to communicate and some drooling. Pupils were pinpoint and fixed. EMS arrived and took over cares. She was transported to [hospital name] via EMS. Resident was still unresponsive when EMS left the building with her. -November 19, 2024, Resident arrived back to the facility at 2:30 p.m. No c/o [complaint of] discomfort. Assist of two pivot transfer with gait belt and wheelchair. Plan of hospice enrollment on November 20, 2024. R2's record lacked a written notice for both hospitalizations that contained, at a minimum: - the reason for the relocation;	01060		

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01060	Continued From page 21 - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - 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; - 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. In addition, R2's records lacked notification to the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days for the hospitalization dated November 14-19, 2024. On December 18, 2024, at 12:20 p.m., assisted living director in residency (ALDIR)-A stated she was not aware of the emergency relocation form, nor the requirement to notify the ombudsman when a resident did not return to the facility within four days. She further stated there have been no emergency relocation notices completed nor notifications to the ombudsman with any resident hospitalization. The licensee's Emergency Relocation policy dated July 31, 2021, indicated [licensee's name] 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. Additionally, the	01060		

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01060	Continued From page 22 policy indicated: in the event of an emergency relocation, [licensee name] will provide a written notice that contains, at a minimum: a. The reason for the relocation b. The name and contact information for the location to which the resident has been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care d. 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 e. A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. 3. The facility will provide contact information for the agency to which the resident may submit an appeal. 4. The notice required will be delivered as soon as practicable to: a. The resident, legal representative, and designated representative b. For residents who receive home and community-based waiver services, the resident's case manager, and c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650		

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01650	Continued From page 23 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident service plans included all the required content for three of three residents (R1, R2, R3). 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	01650		

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01650	Continued From page 24 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 R1 began receiving assisted living with dementia care (ALFDC) services on December 4, 2023, with diagnoses including dementia, type 2 diabetes with insulin dependence, and depression. R1's Service Plan dated December 13, 2024, included medication administration, blood sugar monitoring, assistance with grooming, bathing, and dressing, and behavior management. On December 17, 2024, at 7:03 a.m., the surveyor observed unlicensed personnel (ULP)-I check R1's blood sugar and blood pressure. R2 R2 began receiving ALFDC services on November 20, 2023, with diagnoses including Lewy Body dementia, unspecified Parkinsonism, and anxiety disorder. R2's Service Plan dated October 22, 2024, included medication administration, assistance with bathing, dressing, transfers and ambulation, hospice services, and urinary catheter care. On December 16, 2024, at 2:25 p.m., the surveyor observed ULP-H empty R2's urinary catheter bag. R3	01650		

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01650	Continued From page 25 R3 began receiving ALFDC services on September 12, 2024, with diagnoses including dementia and history of deep vein thrombosis (blood clots) of right lower extremity. R3's Service Plan dated October 9, 2024, included medication administration, assistance with bathing, compressing stockings, and transfers. On December 17, 2024, at 6:45 a.m. the surveyor observed ULP-I donning (putting on) R3's compression stockings. R1, R2, R3's service plans lacked the following: - the schedule and methods of monitoring assessments of the resident; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On December 18, 2024, at 12:10 p.m., assisted living director in residency (ALDIR)-A stated the above listed required content was not included	01650		

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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
01650	Continued From page 26 within the service plan as created with the licensee's EMR (electronic medical record) system. ALDIR-A further stated information regarding how to contact the facility was found in the resident handbook; however, none of the above content was found anywhere in the contract or other paperwork given to the resident. ALDIR-A stated the corporate office was not located in Minnesota and she would need to contact them to determine how to include this required content in the licensee's service plan. The licensee's Service Plan policy dated July 31, 2021, indicated all residents receiving assisted living services will have a service plan in place. Service plans are based on the outcomes of initial and subsequent assessments, reassessments, monitoring, and individual reviews of the resident's needs and preferences. Additionally, the policy indicated the Service Plans would include: -a schedule and method for the next planned assessment or monitoring - a schedule and method for the next planned monitoring of staff providing services - a contingency plan that includes: - actions [licensee name will take if scheduled services cannot be provided - information regarding how the resident can contact [licensee name] - the names and contact information the resident wishes, if any, to have notified in an emergency or if there is a significant adverse change in the resident's condition - identification and contact information of who the resident has authorized, if any, to sign for the resident in an emergency - how the facility will support documented resident health care directive decisions, if any - including circumstances when emergency medical services	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37785	A. BUILDING: _____ B. WING _____	12/19/2024

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CASCADE CREEK MEMORY CARE	3530 FAIRWAY RIDGE LANE SW ROCHESTER, MN 55902

(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
01650	Continued From page 27 are not to be summoned. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01650		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensee's medication refrigerator was maintained at an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations for five of five residents (R1, R2, R9, R10, R11) who had medications stored in the medication refrigerator. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 16, 2024, at 11:00 a.m. during	01880		

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01880	Continued From page 28 entrance conference, clinical nurse supervisor (CNS)-B stated resident medications were securely stored in a medication cabinet and medications that required refrigeration were stored in a small, locked refrigerator in the medication room on both floors of the facility. CNS-B stated she was uncertain whether the refrigerator temperatures were monitored daily. On December 17, 2024, at 11:00 a.m., the surveyor and unlicensed personnel (ULP)-I reviewed the contents of the licensee's small, locked refrigerator found in the locked medication room on the second floor of the facility. The surveyor noted a refrigerator temperature log dated December 2024, in a plastic sheet protector found sitting on top of the small refrigerator. The temperature logged included: -December 16, 2024, with a temperature of 40 degrees Fahrenheit (F). -December 17, 2024, with a temperature of 40 degrees F. Inside the small refrigerator were two thermometers. On the upper shelf, stored with cold packs, a thermometer read 34 degrees F. R1 and R2 medications were found on the middle shelf (no thermometer), and on the lower-level shelf, the surveyor noted another thermometer with a temperature of 44 degrees F. The temperature log lacked an indication of what thermometer was being used to monitor the refrigerator's temperature. The medications stored within the refrigerator included: -R1 Humulin insulin (for diabetes) 100 units/ml (u/ml) pens-two unopened pens; -R2 Oxycodone liquid (for pain/shortness of breath) 5 milligrams/5 milliliter (mg/ml)- four 5 ml	01880		

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	37785	A. BUILDING: _____ B. WING _____	12/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASCADE CREEK MEMORY CARE	3530 FAIRWAY RIDGE LANE SW ROCHESTER, MN 55902

(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
01880	Continued From page 29 oral syringes; and -R2 lorazepam (for anxiety/shortness of breath) 2 mg/ml- five (0.25 ml) oral syringes Humulin insulin manufacturer's instructions dated June 2022, indicated a storage temperature for unused pens in the refrigerator at 36°F to 46°F. Do not freeze your insulin. Do not use if it has been frozen. Oxycodone oral liquid manufacturer's instructions dated April 2024, indicated store at controlled room temperature, 77°F. Protect from moisture and light. Lorazepam liquid manufacturer's instructions dated October 2012, indicated refrigerate 36°-46°F. On December 17, 2024, at 1:30 p.m., the surveyor and registered nurse (RN-C) reviewed the contents of the licensee's small, locked refrigerator found in the locked medication room on the first floor of the facility. The small refrigerator's thermometer indicated a temperature of 41 degrees F. The surveyor noted a refrigerator temperature log for December 2024, in a plastic sheet protector found sitting on top of the small refrigerator. The temperature log indicated: -December 16, 2024, with a temperature of 41 degrees F. -December 17, 2024) with a temperature of 30 degrees F. No other temperatures had been written on the temperature log. The medications stored within the refrigerator included: -R9 latanoprost (eye drops for glaucoma) two	01880		

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	37785	A. BUILDING: _____ B. WING _____	12/19/2024

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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
01880	Continued From page 30 unopened bottles; -R10 Morphine sulfate (for pain/shortness of breath) oral liquid 100 mg/5 ml, nine (0.25 ml) syringes; and -R11 hydromorphone (for pain/shortness of breath) oral liquid, 5 mg/5 ml, 45 (1 ml) syringes Latanoprost manufacturer's instructions dated August 2011, indicated protect from light. Store unopened bottle(s) under refrigeration at 36° to 46°F. Morphine sulfate oral solution manufacturer's instructions October 2021, indicated store at 68° to 77°F. Hydromorphone oral solution manufacturer's instructions dated March 2021, indicated store at 68° to 77°F. The licensee failed to ensure the licensee's medication refrigerators were maintained at acceptable temperatures to ensure the medications were stored according to manufacturer's recommendations. On December 17, 2024, at 1:30 p.m., RN-C stated the medication refrigerator temperatures should have been checked daily and were not. The licensee's Medication Storage policy dated July 31, 2021, indicated medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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	37785	A. BUILDING: _____ B. WING _____	12/19/2024

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01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to label a time sensitive medication with an opened date or included a proper label for three of 45 residents (R5, R7, R8) with medication administration. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings included: MEDICATION OPEN DATE R7 R7's Service Plan dated November 18, 2024, indicated she received the service of medication administration. R7's signed prescriber's orders dated November 18, 2024, for dorzolamide-timolol (eye drops for	01890		

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	37785	A. BUILDING: _____ B. WING _____	12/19/2024

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01890	Continued From page 32 glaucoma) 22.3-6.8 milligrams/milliliter (mg/ml) indicated instill one drop into both eyes twice daily. On December 17, 2024, at 10:50 a.m., the surveyor and unlicensed personnel (ULP)-I reviewed the contents of the facility's second floor locked medication cart. R7's section in the drawer included three opened bottles of dorzolamide/Timolol. None of the bottles indicated an opened date. ULP-I stated she did not know when any of the bottles were opened and stated the ULPs had been trained to include an open date by writing on the label. Dorzolamide-Timolol eye drops-package label for storage indicated "unused units in the pouch at room temperature, protect from freezing, protect from light. Use within one month after the foil package has been opened." MEDICATION LABELS R5 R5's Service Plan dated December 12, 2024, included the service of medication administration. R5's signed prescriber's orders dated December 12, 2024, for Metamucil (for constipation) indicated take one packet three times daily. On December 17, 2024, at 10:50 a.m., the surveyor and ULP-I reviewed the contents of the facility's second floor locked medication cart. R5's section in the drawer included multiple packets of Metamucil sitting loosely in the drawer without a label. ULP-I opened the bottom drawer of the medication cart to show R5's labeled box of Metamucil. Upon further review of other	01890		

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01890	Continued From page 33 medication cart drawers, an unlabeled packet of Metamucil was found lying in another resident's section. ULP-I indicated it was R5's Metamucil and had apparently fell behind and dropped from "her drawer". R8 R8's Service Plan dated December 15, 2024, indicated she received medication administration. R8's signed prescriber's orders dated December 3, 2024, for Symbicort 80-4.5 micrograms/actuation (mcg/actuation) inhaler indicated inhale two puffs by mouth twice daily, rinse mouth after use. (beyond use 90 days). On December 17, 2024, at 1:30 p.m., the surveyor and registered nurse (RN)-C reviewed the contents of the facility's first floor locked medication cart. R8's section of the medication drawer included an unlabeled Symbicort inhaler. RN-C stated it appeared the labeled box for the inhaler had been discarded, and the inhaler was now without a proper label. The inhaler also lacked an opened date. Symbicort manufacturer's instructions dated December 2017, indicated throw away Symbicort when the counter shows zero or three months after you take your inhaler out of its pouch. The licensee's undated, Medication-Over the Counter policy indicated medications stored or administered within the facility must be properly labeled to ensure the safety and well-being of residents and to maintain compliance with state standards. No further information was provided.	01890		

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01890	Continued From page 34 TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the required content for one of one discharged resident (R4). 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	01910		

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01910	Continued From page 35 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: R4's record indicated she began receiving assisted living with dementia care services on November 1, 2023, and was discharged on July 1, 2024. R4's Service Plan dated July 1, 2024, indicated she received medication administration. R4's Medication Administration Record (MAR) dated July 1, 2024, indicated she received one medication for depression, one for blood pressure management, two for pain, one supplement, and one as needed antibiotic. R4's Progress Note dated July 1, 2024, indicated R4 was discharged with family to [assisted living facility name]. The licensee failed to document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. On December 18, 2024, at 2:10 p.m., clinical nurse supervisor (CNS)-B stated, "we don't have one [a medication disposition record] for this resident." The licensee's Medication Disposal policy dated	01910		

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01910	Continued From page 36 July 31, 2024, indicated any current medications being managed by [licensee name] must be provided to the resident when the resident's service plan ends, or medication management services are no longer part of the service plan. Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects	02110		

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02110	Continued From page 37 of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and the resident's legal and designated representative at the time of move-in for three of three residents (R1, R2, R3). 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: The licensee had an assisted living with dementia	02110		

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02110	Continued From page 38 care license effective August 1, 2024. R1, R2, and R3's records lacked evidence of receipt of the required Assisted Living with Dementia Care policies and procedures at the time of resident move-in, to include: - philosophy of how services were provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including non-pharmacological practices that were person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities were implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills only; - transportation coordination and assistance to and from outside medical appointments; and - safekeeping of residents' possessions. On December 18, 2024, at 11:20 a.m., assisted living director in residency (ALDIR)-A stated, "We have the policies as required and share the process during conversations with the families, and at this point there is no language in writing pertaining to sharing dementia policies, and to my knowledge, this has not been part of the	02110		

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02110	Continued From page 39 practice." The licensee's Assisted Living with Dementia Care Additional Required policies dated July 31, 2021, indicated because [licensee's name] had an Assisted Living with Dementia Care license, in addition to the policies and procedures required for the facility written policies and procedures must include additional dementia related policies. In addition, these policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. The policies can be provided in electronic format if desired. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		

Minnesota Department of Health
Environmental Health - FPLS

Rochester

Type: Full
Date: *12/17/24*
Time: 09:30:59
Report: 1038241216

Food and Beverage Establishment Inspection Report

Location:
Cascade Creek Memory Care
3530 Fairway Ridge Lane Sw
Rochester, MN55902
Olmsted County, 55

Establishment Info:
ID #: 0037510
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074147900
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400ppm at Degrees Fahrenheit
Location: Sanitizer Bucket
Violation Issued: No

Hot Water: = at 165 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Hot Water: = at Degrees Fahrenheit
Location:
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Bread
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 30 Degrees Fahrenheit - Location: Bread
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 34 Degrees Fahrenheit - Location: Cheese
Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: 8 Degrees Fahrenheit - Location: Pulled Pork
Violation Issued: No

Type: Full
Date: *12/17/24*
Time: 09:30:59
Report: 1038241216
Cascade Creek Memory Care

Food and Beverage Establishment Inspection Report

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

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

cchandler@cascadecreekmemorycare.com

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 1038241216 of 12/17/24.

Certified Food Protection Manager: Carlton Chandler

Certification Number: FM116358 Expires: 04/25/26

Signed: _____
Establishment Representative

Signed: _____
Rob Davis
Sanitarian 2
Rochester District Office
507-810-9902
rob.davis@state.mn.us