



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 5, 2025

Licensee

Edgewood Hermantown I Senior Living, LLC
4195 Westberg Road
Hermantown, MN 55811

RE: Project Number(s) SL30824016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 24, 2025, 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 . . ."

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0800 - 144g.45 Subd. 2 (a) (4) - Fire Protection And Physical Environment

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessica Chenze".

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/24/2025
NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG			STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD HERMANTOWN, MN 55811		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#30824016-1 On April 23, 2025,through April 24, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on January 29, 2025. At the time of the survey, there were 168 residents receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued and/ or issued.	{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.		
{0 100} SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living	{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 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 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	{0 100}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;	{0 480}			

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{0 480}	Continued From page 3 (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}			
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in	{0 510}	This correction order was not reviewed during this license order follow up.		

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{0 510}	Continued From page 4 assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}	This correction order was not reviewed during this license order follow up.		
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. 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). Findings include: On a facility tour on April 24, 2025, from 10:15 a.m. to 12:15 p.m., with environmental services director (ESD)-N, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code	{0 775}			

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{0 775}	Continued From page 5 (MSFC) in Minnesota Rules Chapter 7511: CARBON MONOXIDE DETECTION There were carbon monoxide alarms installed near the gas fired appliances in the boiler rooms, mechanical rooms, and near the fireplaces in the main building and the separate dementia care building. ESD-N, stated during the tour that the existing carbon monoxide alarms were not tied into the building fire alarm system to sound an alarm notifying building occupants of the presence of carbon monoxide. During the tour ESD-N, provided documentation of a signed proposal agreement with a contractor to install an upgraded fire alarm system to include carbon monoxide detection as required. There was not carbon monoxide alarms installed outside and within ten feet of all sleeping rooms. Carbon monoxide detection and alarms are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511. EXIT DOOR LOCKING The dementia care units were secured with a locked doors from the direction of exit travel. There was not an emergency release button to release all locked doors to open in the direction of exit travel installed in all four locked dementia care units. Emergency release buttons are required to be installed in each locked unit in an area constantly attended by staff. The emergency release button shall release all locked exit doors and exterior gates to the open position in the event of a fire or similar emergency	{0 775}			

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{0 775}	Continued From page 6 in accordance with MSFC in Minnesota Rules Chapter 7511 and the local building and fire code official. The fenced exterior courtyards of both buildings were provided with gates leading to the public way from marked exterior exit doors in the buildings. The exterior gates were provided with magnetic lock key code pads that were located on the non-exit side (outside the fence) and were not accessible to activate the code to open the gate from the exit side. During the tour ESD-N, provided documentation of a signed proposal agreement with a contractor to install an upgraded fire alarm system to include the required emergency release switch for the door controlled egress door locking system. Marked exit door locking systems are required to comply with MSFC in Minnesota Rules Chapter 7511. FIRE-RESISTANT RATED DOORS The door did not automatically close and latch the fire-resistant rated doors, crossing the corridor near resident sleeping room 471, door from great room to corridor, and the storage room door across from resident sleeping room 123. Fire-resistant rated doors are required to be maintained as designed and installed to automatically close and latch. The doors are required to automatically close and latch to protect the path of egress in the corridor in the event of a fire or similar emergency in accordance with MSFC in Minnesota Rules Chapter 7511.	{0 775}			

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{0 775}	Continued From page 7 FIRE SPRINKLER HEAD COVERAGE There were walls built after original construction limiting the coverage of the fire sprinkler heads in the employee bathroom across from resident room 144. Part of the wall was removed but a 6 foot section of the wall was still in place and obstructing fire sprinkler head clearance. The fire sprinkler system sprinkler head coverage is required to be maintained as designed and installed at the time of original construction to include building alterations in accordance with MSFC in Minnesota Rules Chapter 7511, National Fire Protection Association (NFPA), and the local fire and building code official. FIRE-RESISTANT RATED WALL ASSEMBLIES There was a one foot by two-foot hole in the fire-resistant rated wall behind the clothes washer and dryer in the laundry room near resident room 205. The hole was covered with a thin plastic sheet that does not maintain the required fire-resistant rating of the wall. It was explained to ESD-N, that the hole is required to be repaired with drywall material equivalent to the drywall membrane used at the time of construction approval. During the facility tour ESD-N, verified the above listed observations while accompanying on the tour.	{0 775}			
{0 800} SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	{0 800}			

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{0 800}	Continued From page 8 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 maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect more than a limited number of 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 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). Findings include: On a facility tour on April 24, 2025, from 10:15 a.m. to 12:15 p.m., with environmental services director (ESD)-N, the surveyor made the following observations of facility disrepair: The bathroom exhaust fan in resident sleeping room 135 was not working when the power switch was turned on.	{0 800}			

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{0 800}	Continued From page 9 There was a one foot by two-foot hole in the ceiling of the mechanical room near resident room 419. The hole was covered with a thin plastic sheet that does not maintain the required fire-resistant rating of the ceiling. It was explained to ESD-N, that the hole is required to be repaired with drywall material equivalent to the drywall membrane used at the time of construction approval. During the facility tour ESD-N, verified the above listed observations while accompanying on the tour.	{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) 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	{0 810}			

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{01880}	Continued From page 12	{01880}			
{01880} SS=D	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:	{01880}			
{01890} SS=F	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:	{01890}	This correction order was not reviewed during this license order follow up.		
{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	{01910}	This correction order was not reviewed during this license order follow up.		

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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
{01910}	Continued From page 13 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:	{01910}	This correction order was not reviewed during this license order follow up.		
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or	{01940}			

Minnesota Department of Health

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{01940}	Continued From page 14 appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	{01940}	This correction order was not reviewed during this license order follow up.		
{02170} SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and	{02170}			

Minnesota Department of Health

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{02170}	Continued From page 15 included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by:	{02170}			
{02310} SS=D	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:	{02310}	This correction order was not reviewed during this license order follow up.		
{02320} SS=D	144G.91 Subd. 4 (b) Appropriate care and services	{02320}	This correction order was not reviewed during this license order follow up.		

Minnesota Department of Health

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{02320}	Continued From page 16 (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	{02320}	This correction order was not reviewed during this license order follow up.		
{02410} SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal	{02410}			

Minnesota Department of Health
STATE FORM 6899 1BB312 If continuation sheet 18 of 18



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 6, 2025

Licensee

Edgewood Hermantown I Senior Living, LLC
4195 Westberg Road
Hermantown, MN 55811

RE: Project Number(s) SL30824016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 29, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Edgewood Hermantown I Senior Living, LLC. Please contact Jessie Chenze at 218-332-5175 on or before **March 11, 2025**, to schedule the conference call.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2025
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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: SL30824016-0 On January 27, 2025, through January 29, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 168 residents; 168 receiving services under the Assisted Living Facility with Dementia Care license. Immediate correction order was identified on January 28, 2025, for project SL30824016-0, for tag identification 1290. Tag identification 1290 was issued at a scope and level of widespread level three (I).		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.	

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	0 100			
0 100 SS=F	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 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	0 100			

Minnesota Department of Health

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0 100	Continued From page 2 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 and interview, the licensee failed to demonstrate legal responsibility for the control and operation of the facility when the licensee allowed use of facility space by a third-party vendor to provide home care, hospice and therapy services to residents and to outside community members. 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: During the entrance conference on January 27, 2025, at 9:41 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. LALD-A stated the licensee did not employ physical or occupational therapists; however, rent out a space in the building to a company that provides hospice, home care, and therapy services to residents and the community. During a facility tour on January 27, 2025, at 10:18 a.m., with LALD-A, the surveyor observed a	0 100			

Minnesota Department of Health

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0 100	Continued From page 3 sign from [name of hospice agency] posted outside of a room with a table of company flyers and brochures of services. LALD-A stated the hospice and home care agency rent out a couple of spaces in the assisted living building. Another room occupied by [name of therapy agency] had a sign posted outside the door and in the therapy room included a variety of therapy equipment. There was no separate entrance into the hospice, home care or therapy departments, with the only access through doors in the common areas of the building. On January 28, 2025, at 11:36 a.m., LALD-A stated the home care and hospice agency had a separate license, separate employees and were not affiliated with the licensee and just rented space. LALD-A stated they were not aware if the licensee had applied for a variance to allow other providers to rent space from the assisted living building. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with	0 480			

Minnesota Department of Health

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0 480	Continued From page 4 one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part	0 480			

Minnesota Department of Health

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0 480	Continued From page 5 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 28, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510			

Minnesota Department of Health

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0 510	Continued From page 6 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical or nursing standards in regard to infection control for two of four employees (unlicensed personnel (ULP)-E, ULP-R). 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: During the entrance conference on January 27, 2025, at 9:41 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. ULP-E On January 28, 2025, at 8:12 a.m., the surveyor observed registered nurse (RN)-D and ULP-E	0 510			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD HERMANTOWN, MN 55811			
(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
0 510	Continued From page 7 provide personal cares for R10. After providing R10's incontinent cares, ULP-E discarded R10's soiled brief and used disposable wipes into R10's small personal garbage can, which did not have a liner inside the garbage can. ULP-E exited R10's room with the garbage can containing the soiled brief and wipes, carried it through the resident hallway, through the dining room where residents were eating breakfast, and ULP-E dumped the contents into a large open garbage can located in the corner of the dining room. ULP-E set R10's empty garbage can on the floor in the dining room next to another small empty garbage can. On January 28, 2025, at 8:48 a.m., RN-D stated the attached secured unit did have a separate room to dispose of personal garbage and used the main garbage can in the dining room. RN-D stated R10's garbage can should have a liner inside and normally the resident's garbage would be bagged, tied, then disposed into the main garbage in the dining room. RN-D stated the unit bathroom was currently under construction and planned to relocate the main garbage back into the bathroom after the remodel. RN-D stated having an opened garbage can in the dining room was not an ideal location and was only temporary. On January 28, 2025, at 10:47 a.m., clinical nurse supervisor (CNS)-B stated the attached secured unit's bathroom was under construction and normally the main garbage would be stored in the bathroom. CNS-B stated resident's personal garbage's should be bagged and tied up before leaving the resident's room. CNS-B stated staff should not be carrying residents' personal garbage through the dining room and the main garbage should be covered and removed from the dining area.	0 510			

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0 510	Continued From page 8 ULP-R On January 28, 2025, at 11:00 a.m., the surveyor observed a large garbage can located in the resident's dining room near the dining room tables. ULP-R stated the garbage can contained left over food along with soiled briefs and wipes from resident's rooms. ULP-R stated ULP-R placed the garbage can from the laundry room into the dining room, so the garbage can was out of the way while ULP-R completed laundry. On January 28, 2025, at 11:16 a.m., ULP-M stated the large garbage can that contained soiled briefs and wipes was supposed to be kept covered in the laundry room. On January 28, 2025, at 11:26 a.m., ULP-O stated the garbage cans that contained soiled briefs and wipes were supposed to be stored in the laundry rooms. On January 28, 2025, at 11:41 a.m., RN-D stated the garbage cans that contained soiled briefs and wipes were supposed to be store in the laundry rooms and the garbage cans were not to be placed out in the resident's dining room area per infection control policies. On January 29, 2025, at 10:46 a.m., CNS-B stated all staff were trained on infection control upon hire and at least annually. The licensee's Standard Precautions policy dated August 2022, indicated standard precautions would be used by all staff when providing housekeeping or maintenance services to residents. Standard precautions apply to exposure to blood, all body fluids, non-intact skin and mucous membranes. Standard precautions are designed to reduce the risk of transmission of	0 510			

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0 510	Continued From page 9 microorganisms from both recognized and unrecognized sources of infection. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. 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). Findings include: On a facility tour on January 29, 2025, from 11:00 a.m. to 2:15 p.m., with environmental services director (ESD)-N, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511:	0 775			

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0 775	Continued From page 10 CARBON MONOXIDE DETECTION There were carbon monoxide alarms installed near the gas fired appliances in the boiler rooms, mechanical rooms, and near the fireplaces in the main building and the separate dementia care building. ESD-N, stated during the tour that the existing carbon monoxide alarms were not tied into the building fire alarm system to sound an alarm notifying building occupants of the presence of carbon monoxide. There was not carbon monoxide alarms installed outside and within ten feet of all sleeping rooms. Carbon monoxide detection and alarms are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511. EXIT DOOR LOCKING The dementia care units were secured with a locked doors from the direction of exit travel. There was not an emergency release button to release all locked doors to open in the direction of exit travel installed in all four locked dementia care units. Emergency release buttons are required to be installed in each locked unit in an area constantly attended by staff. The emergency release button shall release all locked exit doors to the open position in the event of a fire or similar emergency in accordance with MSFC in Minnesota Rules Chapter 7511 and the local building and fire code official. The fenced exterior courtyards of both buildings were provided with gates leading to the public way from marked exterior exit doors in the	0 775			

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0 775	Continued From page 11 buildings. The exterior gates were provided with magnetic lock key code pads that were located on the non-exit side (outside the fence) and were not accessible to activate the code to open the gate from the exit side. The marked exit door leading from the main assisted living building to the attached dementia care unit was provided with a key code access lock preventing travel in the direction of exit travel. Marked exit doors in this occupancy are required to open in the direction of exit travel without the use of keys tools or special knowledge or with delayed egress locking systems. Marked exit door locking systems are required to comply with MSFC in Minnesota Rules Chapter 7511. FIRE-RESISTANT RATED DOORS The door closers were removed from the fire-resistant rated doors, crossing the corridor near resident sleeping room 471, the environmental services director office, the storage room door across from resident sleeping room 123, and the serving kitchen door near resident sleeping room 402. The door latch was removed, and the door was propped open with a wedge at the bottom on the vending machine room fire-resistant rated door across from resident sleeping room 123. The fire-resistant rated doors between the separate locked units were held open with magnetic hold open devices in the separate dementia care building. The magnetic hold open devices were not tied to the building fire alarms	0 775			

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0 775	Continued From page 12 system in order to automatically close and latch upon fire alarm activation. The fire-resistant rated doors in the corridor were removed from the nurse office and dining room in the dementia care unit attached to the main assisted living building. Several fire-resistant rated resident room doors throughout the facility were held open with different types of devices in order to prevent the door from automatically closing. The devices used to hold the fire-resistant rated doors open were not tied to the building fire alarm system in order to release the doors to close automatically in the event of fire alarm activation. Fire-resistant rated doors are required to be maintained as designed and installed to automatically close and latch. The doors are required to automatically close and latch to protect the path of egress in the corridor in the event of a fire or similar emergency in accordance with MSFC in Minnesota Rules Chapter 7511. EXIT PATH MAINTENANCE The were two large mirrors and one large piece of glass stored in the marked exit corridor vestibule near exterior door marked number six. The exterior exit path leading from the marked exit doors to the public way was covered with snow in all fenced areas of the separate dementia care building. Exit paths are required to be maintained clear of storage and obstructions that prevent full and immediate use of the exit path from the interior of	0 775			

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0 775	Continued From page 13 the building continuous to the public way. MECHANICAL ROOM FRESH COMBUSTION AIR The fresh combustion air intake pipes providing air from the exterior for the gas burning appliances in the mechanical rooms were blocked limiting the capacity of air intake. The mechanical rooms with blocked combustion air intakes include the mechanical room across from resident sleeping room 123, near resident room 302, near resident sleeping room 438, and in unit C of the separate dementia care unit. The mechanical room combustion air intake pipes are required to be maintained clear of obstructions to provide exterior fresh air to the room as designed and constructed. The combustion air requirements shall comply with MSFC and the Minnesota Mechanical Code in Minnesota Rules Chapters 7511 and 1346. SMOKE ALARM MAINTENANCE The smoke alarms were removed during the tour by ESD-N, to check manufacture date and tested in resident sleeping rooms A-5, and C-9, in the separate dementia care building. The smoke alarms removed indicated a manufacture date of 1999 and the alarm in resident room C-9, did not sound properly when tested. Smoke alarms are required to be maintained with a manufacture date of ten years or less in accordance with MSFC in Minnesota Rules Chapter 7511. ELECTRICAL WIRING	0 775			

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0 775	Continued From page 14 There was a permanently installed mini split air conditioner supplied with a permanently installed extension cord plugged into an outlet in the nurse office/ employee break room of the main assisted living building. There was a daisy chained (plugged into multiple devices in series) power strip plugged into another light duty electrical extension cord used to provide power to two stationary appliances in the Office for Family Admissions. Extension cords are required to be used for temporary power only or a power strip providing power to one stationary appliance. There was an open electrical box with exposed electrical wire connections in the mechanical room near resident room 438. There were smoke alarms removed from the ceiling exposing electrical wires in two of the three Caring Edge offices. Electrical wiring and extension cord use is required to comply with MSFC in Minnesota Rules Chapter 7511. FIRE SPRINKLER HEAD COVERAGE There were walls built after original construction limiting the coverage of the fire sprinkler heads in the employee bathroom across from resident room 144 and in the nurse office area adjacent to the dining room in the dementia care unit attached to the main assisted living building. The fire sprinkler system sprinkler head coverage is required to be maintained as designed and installed at the time of original construction to include building alterations in accordance with	0 775			

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0 775	Continued From page 15 MSFC in Minnesota Rules Chapter 7511, National Fire Protection Association (NFPA), and the local fire and building code official. EXIT SIGNS The exit signs were tested and did not operate as required near resident room 435 and the exit sign marking the door separating the assisted living from the attached dementia care unit when traveling from dementia care to the attached assisted living. All exit signs are required to be provided with emergency power to always light the sign lettering the building is occupied. FIRE-RESISTANT RATED WALL ASSEMBLIES There was a one foot by two-foot hole in the fire-resistant rated wall behind the clothes washer and dryer in the laundry room near resident room 205. During the facility tour ESD-N, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775			
0 800 SS=E	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	0 800			

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0 800	Continued From page 16 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 maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect more than a limited number of 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 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). Findings include: On a facility tour on January 29, 2025, from 11:00 a.m. to 2:15 p.m., with environmental services director (ESD)-N, the surveyor made the following observations of facility disrepair: The bathroom exhaust fan in resident sleeping room 135 was not working when the power switch was turned on. The gutter was bent and partially tore off on the back side of the building near the sewer lift station.	0 800			

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0 800	Continued From page 17 There was water damage on the ceiling in the laundry room near resident room 438. There was a one foot by two-foot hole in the ceiling of the mechanical room near resident room 419. During the facility tour ESD-N, verified the above listed observations while accompanying on the 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) 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	0 810			

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0 810	Continued From page 18 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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content, and provide required training. 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 potential to affect a large portion or all of the residents). The findings include: On January 29, 2025, from 10:20 a.m., environmental services director (ESD)-N, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN	0 810			

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0 810	Continued From page 19 The licensee provided FSEP, failed to include the following: The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. During an interview on January 29, 2025, at 10:30 a.m., ESD-N, stated written procedures for residents in the event of a fire or similar emergency were not included in the FSEP but the residents were trained with verbal instruction. TRAINING Record review of the available documentation indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year as evident by not providing documentation the employee training was completed as required. During an interview on January 29, 2025, at 10:40 a.m., ESD-N, stated employee training was completed with evacuation drills, but the documentation provided did not indicate that. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
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	01290			

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01290	Continued From page 20 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 a staff member 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 current employee records contained all the required content to include a background study clearance letter for three of eleven employees (unlicensed personnel (ULP)-F, dining assistant (DA)-I, dining service director (DSD)-K). 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). The findings include: This resulted in an immediate correction order on January 28, 2025. During the entrance conference on January 27, 2025, at 9:41 a.m., licensed assisted living	01290			

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NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD HERMANTOWN, MN 55811			
(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
01290	Continued From page 21 director (LALD)-A stated the licensee had a human resource department in charge of required contents in an employee record. ULP-F ULP-F was hired on June 22, 2001, and had begun to provide direct care services to the residents at the assisted living facility on August 1, 2021. On January 28, 2025, at 9:10 a.m., the surveyor observed ULP-F interact with residents while cleaning up breakfast dishes. ULP-F was not under direct supervision. ULP-F's employee record lacked a cleared NETStudy 2.0 background study. DA-I DA-I was hired on August 11, 2015, and had begun to provide direct dining assistance August 1, 2021, to residents at the facility. On January 28, 2025, at 6:51 a.m., the surveyor observed DA-I in the kitchen located off the resident dining room. DA-I was not under direct supervision. DA-I's employee record lacked a cleared NETStudy 2.0 background study. DSD-K DSD-K was hired on April 27, 2015, and was the DSD effective August 1, 2021, for residents at the facility. DSD-K's employee record contained a cleared NETStudy 2.0 COVID-19 background study, however the background study expired December 31, 2022.	01290			

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01290	Continued From page 22 On January 28, 2025, from 10:34 a.m., through 10:46 a.m., the surveyor reviewed the NETStudy 2.0 website and rosters with business office director (BOD)-L. BOD-L stated the licensee was aware not all employees were not listed on the licensee's NETStudy 2.0 roster and BOD-L had an employee list of background studies that BOD-L needed to submit on NETStudy 2.0. BOD-L completed a search for ULP-F on the NETStudy 2.0 website and the results indicated your entity is no longer affiliated with this person, and you can no longer view this person's profile. BOD-L completed a search for DA-I on the NETStudy 2.0 website and the results indicated no matching criteria. BOD-L stated DSD-K 's original background study was an expired COVID-19 Background Study, and BOD-L did not submit another NETStudy 2.0 background check after DSD's COVID-19 Background Study expired December 31, 2022. BOD-L further stated the licensee had issues with affiliation to the licensee, a credit card that the licensee was no longer able to use, and finger printing locations for the NETStudy 2.0 background study were closed down. BOD-L stated BOD-L was responsible for submitting all background studies on NETStudy 2.0, and the licensee had over 50 current and unsupervised employees to complete a NETStudy 2.0 background study on. On January 28, 2025, at 10:50 a.m., LALD-A stated BOD-L had informed LALD-A of multiple employees not having a cleared background study on NETStudy 2.0 and LALD-A confirmed employes were current and working without direct supervision. The licensee's undated Pre-Employment Background Checks policy indicated background	01290			

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01290	Continued From page 23 studies are conducted by the MN Department of Human Services. Requests may be submitted online using NETStudy, a web base application used to submit requests and receive results online. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to	01650			

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01650	Continued From page 24 (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 the service plan included the required content for three of four residents (R2, R6, R8). 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	01650			

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01650	Continued From page 25 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 include: During the entrance conference on January 27, 2025, at 9:41 a.m., clinical nurse manager (CNS)-B stated the registered nurse managers were responsible for the development and maintaining resident service plans. CNS-B stated resident service plans were updated with changes in resident services, the updated service plan was signed by the resident and or resident's representative, and a copy of the service plan was offered to the resident. R2 R2's diagnoses included cataract surgery (clouding of the eye lenses), paranoid schizophrenia, diabetes type II, history of transient ischemic attack (mini stroke), and depression. On January 27, 2025, at 11:36 a.m., the surveyor observed unlicensed personnel (ULP)-P administering R2's eye drops. R2's Service Plan-Modification dated August 6, 2024, indicated R2 received assistance with medications, oxygen management, tubi grip stocking (compression socks), housekeeping and laundry services. R2's Service Plan lacked the following required content: -the schedule and methods of monitoring assessments of the resident;	01650			

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01650	Continued From page 26 -the schedule and methods of monitoring staff providing services; and -a contingency plan that included: the action to be taken if the scheduled service cannot be provided. On January 29, 2025, at 10:17 a.m., CNS-B stated they were unable to find a service plan in R2's record that included all the required content. CNS-B stated R2's original service plan dated February 2, 2021, was before the licensee implemented RTasks (electronic medical charting program) which included all the required content. CNS-B stated R2's service plan dated August 6, 2024, had been modified; however, was not a complete service plan and was missing the required content noted above. R6 R6's diagnoses included vascular dementia, diabetes, chronic obstructive pulmonary disease (COPD- difficult breathing), and schizophrenia. R6's Service Plan dated February 5, 2019, indicated R6 received medication administration, behavior management, and assistance with bathing, grooming, and dressing. R6's Assessment dated January 20, 2025, indicated Accu Checks (blood glucose checks) were "completed per schedule." Notify nurse of out-of-range results. R6's Treatment Recap Summary dated December 2024, and January 2025, respectively, indicated R6's had blood glucose monitoring twice per day. On January 28, 2025, at 6:53 a.m., the surveyor observed ULP-M complete a scheduled blood	01650			

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01650	Continued From page 27 glucose check for R6. R6's service plan lacked the description of service to be provided, the fee for service, the frequency of the service, and the identification of staff or categories of staff who will provide the service regarding R6's blood glucose checks. On January 29, 2025, at 10:58 a.m., CNS-B provided R6's Service Plan- Modification dated January 28, 2025, however, CNS-B stated R6's updated service plan was printed and authenticated from RTasks, which included all the required content after the surveyor requested R6's service plan. R8 R8's diagnoses included unspecified dementia with behavioral disturbance, hypertension (HTN-high blood pressure), and diabetes. R8's Service Plan- Addendum to Contract dated April 12, 2023, indicated R8 received medication administration, behavior management, and assistance with toileting and dressing. R8's Assessment dated November 26, indicated R8 received blood glucose checks every day and PRN (as needed). R8's Provider Orders dated August 7, 2024, indicated R8 received monitoring of blood glucose PRN. On January 28, 2025, at 7:19 a.m., the surveyor observed ULP-M complete scheduled morning medication administration for R8. R8's service plan lacked the description of service to be provided, the fee for service, the	01650			

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01650	Continued From page 28 frequency of the service, and the identification of staff or categories of staff who will provide the service regarding R8's blood glucose checks. On January 29, 2025, at 10:50 a.m., CNS-B stated R8's service plan had not been revised to include blood glucose checks PRN. CNS-B further stated the licensee must have missed adding R8's blood glucose since the licensee typically updates a resident service plan with any changes of service. The licensee's Service Plan policy dated August 2022, indicated all residents receiving services would have a service plan in place and would include: -description of the services that are to be provided based on the most recent assessment and resident preferences; -fees for services to be provided; -the frequency of each service to be provided based on the most recent assessment and resident preferences; -an identification of staff or categories of staff who would be providing services; -a schedule and method of for the next planned assessment and monitoring; -a schedule and method for the next planned monitoring staff providing services; and -a contingency plan that includes actions the licensee would take if scheduled services could not be provided. In addition, the Service plan policy indicated service plans shall be revised, if needed, based on resident reassessments and monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01650			

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01650	Continued From page 29 (21) days	01650			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per prescriber orders for one of six residents (R7) observed during 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 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:	01760			

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01760	Continued From page 30 During the entrance conference on January 27, 2025, at 9:41 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R7's diagnoses included unspecified dementia, hypertension (HTN-high blood pressure), and pain in right knee. R7's service plan dated June 6, 2024, indicated R7 received medication administration twice daily. R7's prescriber orders dated August 28, 2024, included an order for diclofenac gel 1% to right knee and hip twice daily. R7's Med (medication) Admin (administration) Summary dated January 2025, indicated R7 received diclofenac gel 1% applied to right knee and hip twice daily. On January 28, 2025, at 6:59 a.m., the surveyor observed unlicensed personnel (ULP)-M conduct a medication pass for R7, which included topical administration of R7's diclofenac gel 1%. ULP-M compared the prescription label with R7's electronic medication administration record (EMAR) and went to R7's room. ULP-M applied R7's diclofenac gel 1% to R7's left knee and hip. Immediately following the observation, ULP-M stated ULP-M applied R7's diclofenac gel to R7's left knee and hip instead of R7's right knee and hip. ULP-M returned to the computer and documented on R7's EMAR diclofenac gel 1% was applied to R7's right knee and hip as ordered. On January 28, 2025, at 11:15 a.m., ULP-M	01760			

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01760	Continued From page 31 stated ULP-M reported R7's medication error to registered nurse (RN)-D. On January 28, 2025, at 11:24 a.m., ULP-O stated ULPs were trained to immediately report to the RN for any medication errors and follow the instructions given by the RN. On January 28, 2025, at 11:38 a.m., RN-D stated ULPs were to immediately report any medication errors to the RN, fill out a medication error report, and ULPs were to document on the resident's EMAR the administration of the medication was not done administered per prescriber orders. On January 29, 2025, at 10:48 a.m., CNS-B stated ULPs were supposed to notify the nurse right away for any medication errors and then ULPs were supposed to complete a medication error report. CNS-B further stated ULPs were to document on the resident's EMARs if a medication was administered incorrectly. The licensee's Medication Errors and Reporting policy dated July 2024, indicated training was provided to personnel with responsibilities related to medication administration. The following checks are performed immediately prior to medications administration: -the right medications; -the right dose; -the right resident; -the right route using the right dosage form- -the right time; and -the right documentation. The licensee's Medication Administration policy dated July 2024, indicated medications administered or provided by the community would be administered by appropriately trained (or	01760			

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01760	Continued From page 32 licensed as required by state regulation) in the 6 Rights of Medication Administration [sic]. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=D	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 one of four refrigerators storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. 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: During the entrance conference on January 27, 2025, at 9:41 a.m., licensed assisted living	01880			

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01880	Continued From page 33 director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. On January 28, 2025, at 11:42 a.m., registered nurse (RN)-D stated the current medication refrigerator temperature located in the secured dementia unit was 36 degrees Fahrenheit (F), staff checked the medication refrigerator temperature every shift, and the medication refrigerator contained the following medications: -two unopened Lantus 100 units/milliliter (mL) insulin pens for R6 -one unopened Lantus 100 units/mL insulin pen for R8 -six unopened Latanoprost solution 0.005% bottles for R8 The licensee's Temp (temperature)- Med (medication) Room Fridge dated December 18, 2024, through January 28, 2025, indicated the medication refrigerator temperature was checked every morning at 7:00 a.m., and the acceptable temperature range is 36 degrees F to 46 degrees F. If temperature is out of range, staff to notify the nurse immediately. Staff to set an alarm to recheck after one hour and report back to the nurse. The Temp Med Room Fridge log indicated the following: -38 of 39 opportunities the medication refrigerator temperature was recorded; and -four out of 38 opportunities the medication refrigerator temperature was out of range and the medication refrigerator temperature was recorded less than 36 degrees F with no documentation of the nurse who was contacted or a recheck of the refrigerator temperature after one hour. On January 29, 2025, at 10:54 a.m., CNS-B stated medication refrigerator temperatures were	01880			

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01880	Continued From page 34 to be set between 36 degrees F to 46 degrees F. CNS-B further stated if the medication refrigerator temperature was out of range staff were to follow the directions located on the medication refrigerator, document what staff had done to adjust the medication refrigerator temperature, and staff should have rechecked the medication refrigerator temperature after adjusting the medication refrigerator settings. The manufacturer's instructions for Lantus dated May 2019, indicated to store unopened Lantus in the refrigerator at 36 degrees F to 46 degrees F. Do not allow Lantus to freeze. The manufacturer's instructions for Latanoprost dated September 2020, indicated to store unopened Latanoprost in the refrigerator at 36 degrees F to 46 degrees F. The licensee's Medication Refrigeration/Freezing Monitoring policy dated July 2024, indicated staff must check weekly or more often as state regulation requires, confirming the refrigerator used to store medications maintains a temperature between 36 degrees F and 46 degrees F. Staff should be instructed that temperatures outside this range must be reported to the supervisor immediately. The licensee's undated Medication Storage policy indicted when medications are managed and stored by the licensee, medications would be kept securely locked and stored per manufacturer's directions. Medication refrigeration temperatures would be checked daily and logged into Rtasks (electronic charting system) If the temperatures are out of range, the nurse would be notified. Nurse would direct staff to adjust the temperature, and staff to notify the nurse again if	01880			

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NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG			STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD HERMANTOWN, MN 55811		
(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 35 out of range in one hour. If temperature is still out of range after one hour, nurse to notify pharmacy to make sure medications are still properly stored. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=F	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 ensure medications were maintained to include the opened date and expiration date for time sensitive medications stored and managed by the licensee, 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:	01890			

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01890	Continued From page 36 During the entrance conference on January 27, 2025, at 9:41 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. On January 27, 2025, at 10:28 a.m., the surveyor reviewed medication cart one with unlicensed personnel (ULP)-P and observed the following: -R2's opened Symbicort and Incruse Ellipta inhalers (used for chronic obstructive pulmonary disease (COPD) lacked the date the inhalers had been opened and when the inhalers would expire. At the time of the observation of medication cart one, ULP-P stated they have been trained to date insulin pens and eye drops when opened; however, were not directed to document the date on the inhalers when opened. On January 28, 2025, at 3:22 p.m., CNS-B stated residents' inhalers would not have a date written on the inhaler when the inhaler was first opened because it was not a part of staff training and staff were trained only to document the open date on all insulin pens and eye drops. The manufacturer's instructions for Symbicort inhaler dated December 2017, indicted to throw away Symbicort when the counter reaches zero or three months after Symbicort was opened, whichever comes first. The manufacturer's instructions for Incruse Ellipta inhaler dated December 2023, indicated to throw away six weeks after opened or when the counter reads zero whichever comes first. Write the date on the label when the inhaler was opened.	01890			

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01890	Continued From page 37 The licensee's undated Medication Storage policy indicted when medications were managed and stored by the licensee, medications would be kept securely locked and stored per manufacturer's directions. No further information was provided. 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	01910			

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01910	Continued From page 38 licensee failed to document in the resident's record the required content on disposition of the medications for one of one resident (R1) upon discharge. 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 finding include: The licensee's Discharged Resident/Client Roster dated October 27, 2024, to January 27, 2025, indicated R1 was admitted to the facility on June 12, 2023, and was discharged on December 31, 2024, to a higher level of care. R1's December 2024, Medication Administration Summary indicated R1 was administered the following medications: -amlodipine 5 milligrams (mg) one tablet daily used to treat high blood pressure; -atorvastatin 80 mg one tablet daily used to treat high cholesterol; -fluoxetine 20 mg one capsule daily used to treat depression; -lisinopril 40 mg one tablet daily used to treat high blood pressure; -naltrexone 50 mg two tables daily used to help treat alcohol or opioid use disorders; -vitamin B-12 1,000 micrograms (mcg) one tablet daily for supplementation; and -Xarelto 20 mg one tablet daily used to reduce/prevent blood clots.	01910			

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01910	Continued From page 39 R1's Discharge -Transfer Summary dated December 31, 2024, indicted R1 was discharged on December 31, 2024, and R1's medications were destroyed per facility protocol. R1's record lacked documentation of the disposition of the above medications to include the medication name, strength, quantity, prescription numbers as applicable, to whom the medications were given, date of disposition, and names of staff or other individuals involved in the deposition. On January 17, 2025, at 3:22 p.m., clinical nurse supervisor (CNS)-B confirmed R1's disposition of medication summary did not include the required documentation of the disposition of R1's medications. CNS-B stated they were aware of the requirements and R1's record should have included the disposition of R1's medications that were destroyed by the licensee. The undated licensee's Medication Disposal policy indicated current unused medications managed by the [licensee name] would be returned to the pharmacy for credit, given to the resident or resident's representative, when the resident's medications are no longer managed by the facility, or the medication has been discontinued by the prescriber. 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.	01910			

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01910	Continued From page 40	01910			
	TIME PERIOD FOR CORRECTION: Seven (7) days				
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced	01940			

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01940	Continued From page 41 by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of four residents (R8) who had treatments or therapies managed by the licensee. 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 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: During the entrance conference on January 27, 2025, at 9:41 a.m., clinical nurse manager (CNS)-B stated the licensee provided treatment management services, including blood glucose checks, to residents at the facility. R8's diagnoses included unspecified dementia with behavioral disturbance, hypertension (HTN-high blood pressure), and diabetes. R8's Service Plan- Addendum to Contract dated April 12, 2023, indicated R8 received medication administration, behavior management, and assistance with toileting and dressing, however, lacked R8 received blood glucose checks PRN (as needed). R8's Provider Orders dated August 7, 2024, indicated R8 received monitoring of blood glucose PRN.	01940			

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01940	Continued From page 42 R8's Assessment dated November 26, indicated R8 received blood glucose checks every day and PRN. R8's Individualized Medication Management Plan dated December 19, 2024, indicated R8 received blood glucose checks every day and PRN. In addition, R8 needed help with blood glucose finger stick checks. On January 28, 2025, at 7:19 a.m., the surveyor observed unlicensed personnel (ULP)-M complete scheduled morning medication administration for R8. R8's record lacked a treatment plan including the following required information regarding blood glucose checks PRN: -written statement of the treatment or therapy that would be provided; -documentation of specific resident instructions relating to the treatment; -identification of treatment or therapy task that would be delegated to ULPs; -procedures for notifying a registered nurse (RN) when a problem arose with the treatment; and -and resident-specific requirements relating to documentation of treatment or therapy received, verification that all treatment or therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On January 28, 2025, at 3:15 p.m., CNS-B stated R8 received blood glucose checks PRN and R8 had not had a blood glucose check for at least two months. On January 29, 2025, at 10:50 a.m., CNS-B stated R8's individualized treatment plan did not	01940			

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01940	Continued From page 43 include R8's blood glucose checks PRN. CNS-B further stated the licensee was aware of the requirement for an individualized treatment plan to include any resident PRN treatments as well. The licensee's undated Treatment and Therapy Management Plan policy indicated the licensee would develop and maintain a current individual treatment and therapy management record for each resident which must include at least the following: -a statement of the type of services that would be provided; -documentation of specific resident instructions relating to the treatment or therapy administration; -identification of treatment or therapy tasks that would be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; -any resident specific requirements relating to documentation of treatment and therapy received; -verification that all treatment and therapy was administered as prescribed; and -monitoring of treatment or therapy to prevent possible complications or adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In	02170			

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02170	Continued From page 44 addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized activity plan for two of two residents (R6, R8) who resided in an assisted living with	02170			

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02170	Continued From page 45 dementia care facility. 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: The licensee held an assisted living with dementia care license effective September 1, 2024, with an expiration date of August 31, 2025. During the entrance conference on January 27, 2025, at 9:41 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R6 R6's diagnoses included vascular dementia, diabetes, chronic obstructive pulmonary disease (COPD- difficult breathing), and schizophrenia. R6's Service Plan dated February 5, 2019, indicated R6 received medication administration, behavior management, and assistance with bathing, grooming, and dressing. On January 28, 2025, at 6:53 a.m., the surveyor observed unlicensed personnel (ULP)-M complete a scheduled blood glucose check for R6. R6's Individualized Activity Plan dated September	02170			

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02170	Continued From page 46 16, 2024, included an evaluation of the activity areas which were required, however, R6's record did not include an individualized activity plan with structured and non-structured activities specific for R6. R8 R8's diagnoses included unspecified dementia with behavioral disturbance, hypertension (HTN-high blood pressure), and diabetes. R8's Service Plan-Addendum to Contract dated April 12, 2023, indicated R8 received medication administration, behavior management, and assistance with toileting and dressing. On January 28, 2025, at 7:19 a.m., the surveyor observed ULP-M complete scheduled morning medication administration for R8. R8's Individualized Activity Plan dated September 16, 2024, included an evaluation of the activity areas which were required, however, R8's record did not include an individualized activity plan with structured and non-structured activities specific for R8. On January 29, 2025, at 10:52 a.m., clinical nurse supervisor (CNS)-B stated the licensee completed the same individualized evaluation on each resident, however, the activity person may have not listed individual structured and non-structured activities specific to each resident. CNS-B further stated CNS-B thought the structured and non-structured activities may be in the resident assessment. The surveyor requested to review additional documentation for activities, however, no further documentation was provided. The licensee's undated Enrichment Programs,	02170			

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02170	Continued From page 47 Activities and Outdoor Space policy indicated an individualized activity plan must be developed for each resident based on their activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170			
02310 SS=D	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 with regards to safely storing oxygen 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) 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: During the entrance conference on January 27,	02310			

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02310	Continued From page 48 2025, at 9:41 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. On January 28, 2025, at 6:53 a.m., the surveyor observed unlicensed personnel (ULP)-M complete a scheduled blood glucose check for R6 in R6's room. The surveyor observed five upright oxygen tanks stored in a rack in R4's small closet and one upright oxygen tank not in a rack or secured by chains placed directly in front of R4's closet. On January 28, 2025, at 7:53 a.m., ULP-M stated R6's oxygen tank located outside of R6's rack was empty and was not placed back into R6's oxygen rack. On January 28, 2025, at 11:22 a.m., ULP-O stated oxygen tanks were supposed to be stored in racks located in R4's closet. On January 28, 2025, at 11:33 a.m., registered nurse (RN)-D stated if an oxygen tank were supposed to be laid down if there is no space in the rack to place the oxygen tank. RN-D further stated the licensee must be short one rack as typically there were enough storage racks to hold all oxygen tanks. On January 29, 2025, at 10:44 a.m., clinical nurse supervisor (CNS)-B stated all oxygen tanks needed to be secured in a rack located in the resident's closet. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99),	02310			

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NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD HERMANTOWN, MN 55811			
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02310	Continued From page 49 indicated a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310			
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of three employees (unlicensed personnel (ULP)-M) observed administering medications. 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	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD HERMANTOWN, MN 55811			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02320	Continued From page 50 situation has occurred only occasionally). The findings include: During the entrance conference on January 27, 2025, at 9:41 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. R6's diagnoses included vascular dementia, diabetes, chronic obstructive pulmonary disease (COPD- difficult breathing), and schizophrenia. R6's Service Plan dated February 5, 2019, indicated R6 received medication administration. R6's prescriber orders dated September 27, 2024, included an order for Stiolto 2.5-2.5 micrograms (mcg) inhale two puffs daily. R6's Med (medication) Admin (administration) Summary dated December 2025, and January 2025, respectively, indicated Stiolto Aer 2.5-2.5 inhaler; administer two puffs by mouth daily. Rinse and spit after. On January 28, 2025, at 8:28 a.m., the surveyor observed ULP-M conduct a medication pass for R6. ULP-M compared the prescription label to the electronic medication administration record (EMAR), handed R6 the Stiolto inhaler for self-administration, and R6 returned the Stiolto inhaler back to ULP-M. ULP-M handed R6's scheduled morning oral medications with a glass of water to R6, R6 took the medication, and swallowed the water. The surveyor did not observe ULP-M offer R6 water to rinse and spit out after inhalation of the Stiolto inhaler.	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG			STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD HERMANTOWN, MN 55811		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02320	Continued From page 51 On January 28, 2025, at 11:15 a.m., ULP-M stated ULP-M did not offer R6 water to rinse and spit after the use of the Stiolto inhaler, however, ULP-M stated R6 normally refused to rinse and spit after the use of R6's Stiolto inhaler. On January 28, 2025, at 11:24 a.m., ULP-O stated ULPs were trained to offer a resident a cup of water to rinse and spit after an inhaler administration. On January 28, 2025, at 11:37 a.m., registered nurse (RN)-D stated ULPs were specifically trained to offer the resident water to rinse and spit after an inhaler administration. On January 29, 2025, at 10:47 a.m., CNS-B stated upon hire and during medication training ULPs were trained to offer a resident water to rinse and spit out after inhaler use. The licensee's undated Medication Management policy indicated for active assistance with medications ULPs will use the MAR, which would also include the purpose of the medication and any special instructions is applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD HERMANTOWN, MN 55811			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02410	Continued From page 52 resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of six residents (R8) while receiving services. 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:	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG			STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD HERMANTOWN, MN 55811		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02410	Continued From page 53 During the entrance conference on January 27, 2025, at 9:41 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R8's record indicated R8 received the Minnesota Bill of Rights for Assisted Living Residents dated April 8, 2023. On January 28, 2025, at 7: 19 a.m., the surveyor observed unlicensed personnel (ULP)-M complete scheduled medication administration for R8 in R8's room. R8's bed was located directly across the room from R8's window, which faced the parking lot and sidewalk used for any residents, staff, or visitors. The window blind was pulled down and covered approximately ¾ of the window, which allowed anyone to still be able to look into R8's room through the lower portion of the window. ULP-M instructed R8 to pull R8's pants and brief down, which fully exposed R8's groin area, and to lay down on R8's bed. ULP-M provided peri care, applied topical medications to R8's groin, R8 stood up, and pulled up R8's brief and pants. On January 28, 2025, at 11:12 a.m., ULP-M stated ULP-M should have closed R8's window blinds completely to provide privacy during R8's cares. On January 28, 2025, at 11:22 a.m., ULP-O stated ULPs were trained to shut resident's doors and close the window blinds for privacy while performing care in a resident room. On January 28, 2025, at 11:35 a.m., registered nurse (RN)-D stated window blinds should be shut during resident cares, so no one was able to	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG			STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD HERMANTOWN, MN 55811		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02410	Continued From page 54 see into the resident's room. On January 29, 2025, at 10:45 a.m., clinical nurse supervisor (CNS)-B stated all window blinds and resident's doors were to be fully shut for privacy during resident cares. The licensee's Resident Dignity policy dated July 2022, indicated the licensee strives to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and individuality. Staff are trained on each person's individual plan of care. This means staff must carry out activities in a manner which assists the resident to maintain and enhance his/her self-esteem and self-worth. Maintaining a resident's dignity included personal care is provided in private as appropriate when needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410			

Type: Full
Date: 01/28/25
Time: 11:30:30
Report: 7980251010

Food and Beverage Establishment Inspection Report

Page 1

Location:

Edgewood Hermantown I Sr Lvg - Assisted Living Fire
Side Serving Kitchen
4195 Westberg Road
Hermantown, MN55811
St. Louis County, 69

Establishment Info:

ID #: 0038916
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2187238905
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.

4-300 Equipment Numbers and Capacities

4-302.13B **** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

A DUAL READ WATERPROOF THERMOMETER OR 160F THERMO LABEL IS REQUIRED TO PROVE DISH MACHINE IS REACHING A MINIMUM PLATE TEMP OF 160F

Comply By: 02/11/25

4-500 Equipment Maintenance and Operation

4-501.110 **** Priority 2 ****

MN Rule 4626.0785 Provide the proper wash water temperature for the warewashing machine as specified in rule and the manufacturer's data plate.

DATA PLATE REQUIRES MINIMUM WASH OF 150F, WAS REGISTERED AT 140F ON MACHINE.
PLATE SANITIZING TEMP WAS REACHED. HAVE MACHINE SERVICED/CALIBRATED

Comply By: 02/11/25

Surface and Equipment Sanitizers

Sink and Surface: = 700 at Degrees Fahrenheit
Location: Sani bucket
Violation Issued: No

Hot Water: = at 140 Degrees Fahrenheit
Location: Dish machine wash
Violation Issued: Yes

Type: Full
Date: 01/28/25
Time: 11:30:30
Report: 7980251010

Food and Beverage Establishment Inspection Report

Page 2

Edgewood Hermantown I Sr Lvg - Assisted Living Fire Side Serving Kitchen

Hot Water: = at 188 Degrees Fahrenheit
Location: Dish machine rinse, label black
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Receiving
Temperature: 182 Degrees Fahrenheit - Location: Hungarian chicken
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: True-creamer
Violation Issued: No

Process/Item: Under Counter Freezer
Temperature: Degrees Fahrenheit - Location: All items frozen hard
Violation Issued: No

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

Notes

1. Kitchen is used to serve meals all food is prepared in the main kitchen, delivered then served from steam table.
2. Staff demonstrated proper hand washing, proper food safety, receiving temperatures were taken by staff when food arrived.
3. Discussed employee illness, any staff with vomiting and/or diarrhea is excluded for 24 hours after symptoms stop. All illness is recorded in the illness log.

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

I acknowledge receipt of the MDH inspection report number 7980251010 of 01/28/25.

Certified Food Protection Manager Michael Kahlar

Certification Number: 62421 Expires: 07/09/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Traci McLeod
Foodservice Dir

Signed: Sara Bents

Sara Bents
Environmental Health Specialist
Duluth
218-302-6184
sara.bents@state.mn.us



MDH

11 E Superior Street
Duluth
218-302-6166

Type: Full
Date: 01/28/25
Time: 12:34:48
Report: 7980251011

Food and Beverage Establishment Inspection Report

Page 1

Location:

Edgewood Hermantown I Sr Lvg - Memory care
4195 Westberg Road
Hermantown, MN55811
St. Louis County, 69

Establishment Info:

ID #: 0038916
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2187238905
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.

4-300 Equipment Numbers and Capacities

4-302.13B **** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

DATA PLATE REQUIRES MINIMUM WASH OF 150F, WAS REGISTERED AT 140F ON MACHINE.
PLATE SANITIZING TEMP WAS REACHED. HAVE MACHINE SERVICED/CALIBRATED

Comply By: 02/11/25

4-500 Equipment Maintenance and Operation

4-501.110 **** Priority 2 ****

MN Rule 4626.0785 Provide the proper wash water temperature for the warewashing machine as specified in rule and the manufacturer's data plate.

DISH MACHINE WAS READ 139F, MINIMUM REQUIRED TEMP IS 150F. PLATE SANITIZING
TEMPERATURE WAS REACHED. HAVE MACHINE SERVICED/CALIBRATED

Comply By: 02/11/25

Surface and Equipment Sanitizers

Hot Water: = at 139 Degrees Fahrenheit

Location: Dish machine wash

Violation Issued: Yes

Hot Water: = at 180 Degrees Fahrenheit

Location: Dish machine rinse, label black

Violation Issued: No

Type: Full
Date: 01/28/25
Time: 12:34:48
Report: 7980251011
Edgewood Hermantown I Sr Lvg - Memory care

Food and Beverage Establishment Inspection Report

Sink and Surface: = 700 at Degrees Fahrenheit
Location: Sanitizer bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Steam Table
Temperature: 199 Degrees Fahrenheit - Location: Lasagne
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: frozen hard
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Shredded cheese
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: Sliced turkey lunch meat
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: Salads
Violation Issued: No

Process/Item: Cooking
Temperature: 184 Degrees Fahrenheit - Location: Soup
Violation Issued: No

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

Notes

1. Kitchen prepares food for memory care building. Main kitchen in assisted living has additional dry and refrigeration/freezer storage since space is limited in this kitchen.
2. Staff demonstrated proper hand washing and proper food handling during inspection.
3. Discussed employee illness, any staff with vomiting and/or diarrhea is excluded for 24 hours after symptoms stop. All illness is recorded in the illness log.

Type: Full
Date: 01/28/25
Time: 12:34:48
Report: 7980251011

Edgewood Hermantown I Sr Lvg - Memory care

Food and Beverage Establishment Inspection Report

Page 3

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

I acknowledge receipt of the MDH inspection report number 7980251011 of 01/28/25.

Certified Food Protection Manager Sierra Wald

Certification Number: 13460 Expires: 09/07/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Traci McLeod
Foodservice Dir

Signed: Sara Bents

Sara Bents
Environmental Health Specialist
Duluth
218-302-6184
sara.bents@state.mn.us



MDH

11 E Superior Street
Duluth
218-302-6166

Type: Full
Date: 01/28/25
Time: 12:30:41
Report: 7980251009

Food and Beverage Establishment Inspection Report

Page 1

Location:

Edgewood Hermantown I Sr Lvg - Assisted Living
Main Kitchen
4195 Westberg Road
Hermantown, MN55811
St. Louis County, 69

Establishment Info:

ID #: 0038916
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/25

Operator:

Phone #: 2187238905
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.

4-300 Equipment Numbers and Capacities

4-302.13B **** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

HOT WATER DISH MACHINES REQUIRE A DUAL TEMP WATER PROOF THERMOMETER OR 160F THERMO LABELS TO PROVE MACHINE IS SANITIZING TEST DAILY

Comply By: 02/11/25

Surface and Equipment Sanitizers

Hot Water: = at 150 Degrees Fahrenheit
Location: Dish machine wash
Violation Issued: No

Hot Water: = at 186 Degrees Fahrenheit
Location: Dish machine rinse, label black
Violation Issued: No

Sink and Surface: = 700 at Degrees Fahrenheit
Location: Sani bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: Butter
Violation Issued: No

Type: Full
Date: 01/28/25
Time: 12:30:41
Report: 7980251009

Food and Beverage Establishment
Inspection Report

Edgewood Hermantown I Sr Lvg - Assisted Living Main Kitchen

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: Ground beef
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 37 Degrees Fahrenheit - Location: Diced tomatoes
Violation Issued: No

Process/Item: Cooking
Temperature: 185 Degrees Fahrenheit - Location: Potatoes
Violation Issued: No

Process/Item: Cooking
Temperature: 188 Degrees Fahrenheit - Location: Mixed vegetables
Violation Issued: No

Process/Item: Cooking
Temperature: 163 Degrees Fahrenheit - Location: Quinoa
Violation Issued: No

Process/Item: Cooking
Temperature: 187 Degrees Fahrenheit - Location: Lasagne
Violation Issued: No

Process/Item: Prep Cooler
Temperature: 40 Degrees Fahrenheit - Location: Tuna salad
Violation Issued: No

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

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

Notes

- 1. Discussed employee illness any staff with vomiting and/or diarrhea is excluded for 24 hours after symptoms stop. All illness is recorded in the illness log.
- 2. Staff demonstrated proper hand washing and food safety knowledge during inspection
- 3. If using the true prep cooler for salad/sandwich prep make sure to install the divider rails and use the correct size metal or plastic food pans. The unit is used for storage now not prep. With the lid open and no pans the unit will not be able to maintain proper temperature.

Type: Full
Date: 01/28/25
Time: 12:30:41
Report: 7980251009

Food and Beverage Establishment Inspection Report

Page 3

Edgewood Hermantown I Sr Lvg - Assisted Living Main Kitchen

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

I acknowledge receipt of the MDH inspection report number 7980251009 of 01/28/25.

Certified Food Protection Manager Michael Khalar

Certification Number: 62421 Expires: 07/09/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Traci McLeod
Foodservice Director

Signed: Sara Bents

Sara Bents
Environmental Health Specialist
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218-302-6184
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