Electronically Delivered

May 19, 2026

Licensee
Edgewood EGF Senior Living
608 5th Avenue Northwest
East Grand Forks, MN 56721

RE: Project Number(s) SL30631016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 1, 2026, 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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, 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

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL30631016-0 On March 31, 2026, through April 1, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 30 residents; 30 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 345 SS=C	144G.30 Subd. 5. (c)(2), (d) Correction orders (c)(2) make available, in a manner readily	0 345		

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0 345	Continued From page 1 accessible to residents and others, including provision of a paper copy upon request, the most recent plan of correction documenting the actions taken by the facility to comply with the correction order. (d) After the plan of correction is made available under paragraph (c), clause (2), the facility must provide a copy of the facility's most recent plan of correction to any individual who requests it. A copy of the most recent plan of correction must be provided within 30 days after the request and in a format determined by the facility, except the facility must make reasonable accommodations in providing the plan of correction in another format, including a paper copy, upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to make available the most recent plan of correction in a manner readily accessible to residents and others, including provision of a paper copy upon request, documenting the actions taken by the facility to comply with the correction orders, after a survey concluded on May 24, 2023. This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On April 1, 2026, at 10:11 a.m., the surveyor requested the licensee to provide a copy of the	0 345		

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0 345	Continued From page 2 facility's most recent plan of correction from the survey completed on May 24, 2023. On April 1, 2026, at 10:33 a.m., licensed assisted living director (LALD)-C provided the surveyor with a copy of the State Form 6899 from the survey that had concluded on May 24, 2023. LALD-C confirmed the form did not indicate a plan of correction. On April 1, 2026, at 10:59 a.m., LALD-C confirmed they could not find the written plan of correction from the previous survey completed in 2023. On April 1, 2026, at 11:18 a.m., LALD-C stated they had spoken to the licensee's president who had also confirmed they did not have a plan of correction. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 345		
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	0 480		

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0 480	Continued From page 3 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 4626.1390, toilet rooms are not required to be provided with a self-closing door.	0 480		

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0 480	Continued From page 4 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 1, 2026, 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		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:	0 640		

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0 640	Continued From page 5 (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information for reporting to Minnesota Adult Abuse Reporting Center (MAARC). 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 the potential to affect a large portion or all of the residents). The findings include: On March 31, 2026, at 11:09 a.m., during a facility tour, the surveyor did not observe information posted for reporting crime and suspected maltreatment to MAARC. On March 31, 2026, at 11:54 a.m., licensed assisted living director (LALD)-C stated they did not think they had the required information posted; and they would post the information.	0 640		

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0 640	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for two of two unlicensed personnel ((ULP)-A, ULP-B).	0 650		

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0 650	Continued From page 7 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 the potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on May 6, 2024. On April 1, 2026, at 7:51 a.m., the surveyor observed ULP-A assist four residents with going to the dining room for breakfast that included assistance with toileting, dressing, standby assistance with ambulation, meal set up, and preparing beverages for residents. ULP-A's employee record lacked evidence of training and competency evaluation by the registered nurse (RN) for performed treatments that included oxygen, compression stockings, continuous positive airway pressure (CPAP), bilevel positive airway pressure (BiPAP), simple wound care, and unplanned time away. On April 1, 2026, at 2:29 p.m., ULP-A stated they were trained and had returned demonstrations to the RN on treatments for oxygen, compression stockings, CPAP/BiPAP, and when a resident had an unplanned time away from the facility that would require medications to be sent with the resident. On April 1, 2026, at 3:54 p.m., clinical nurse	0 650		

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0 650	Continued From page 8 supervisor (CNS)-D stated they had trained and observed ULP-A perform treatments for simple wound care, oxygen, and unplanned time away. RN-G stated they currently performed weekly wound care with ULP-A. ULP-B ULP-B was hired on January 2, 2026. ULP-B's employee record lacked evidence of the following training required: - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety; - preparation of modified diets as orders by a licensed health professional; - procedures to utilize in handling various emergency situations; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the residents. ULP-B's employee record lacked evidence of training and competency evaluation by the RN for medication administration of all routes except nebulizer and naloxone; unplanned time away; and performed treatments that included blood glucose and simple wound care. On April 1, 2026, at 10:11 a.m., licensed assisted living director (LALD)-C stated they had some competency evaluations missing from the personnel records from previous years, which included ULP-B. LALD-C stated they had been working diligently to get the personnel files in compliance. The licensee's Employee Records Management	0 650		

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0 650	Continued From page 9 policy dated September 2019 indicated any documents related to training or orientation that an employee received while with the company would be in a training file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include a baseline TB screening that included a two-step tuberculin skin test (TST) or	0 660		

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0 660	Continued From page 10 other evidence of TB testing such as IGRA (a blood test); and failed to provide TB training upon hire and annually for two of two unlicensed personnel ((ULP)-A, ULP-B). 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 the potential to affect a large portion or all of the residents). The findings include: The licensee's Facility TB Risk Assessment dated July 28, 2025, indicated the facility was at a low risk for TB transmission. ULP-A ULP-A was hired on May 6, 2024. On April 1, 2026, at 7:51 a.m., the surveyor observed ULP-A assist four residents with going to the dining room for breakfast that included assistance with toileting, dressing, standby assistance with ambulation, meal set up, and preparing beverages for residents. ULP-A's Baseline TB Screening Tool for Health Care Workers (HCWs) dated January 15, 2025, indicated ULP-A had an assessment for history and current symptoms of active TB disease. Also, ULP-A had a first step TST administered on January 8, 2025, and a second step TST administered on January 15, 2025, however there were no results documented for both TST as this	0 660		

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0 660	Continued From page 11 was left blank. The TB baseline screening was completed 254 days after the date of hire. ULP-A's personnel record lacked TB training upon hire and annual TB training in 2025. On April 1, 2026, at 2:29 p.m., ULP-A stated they did not recall being trained on TB. ULP-A stated they did not know what TB was, how TB was spread, or the signs and symptoms of TB. ULP-B ULP-B was hired on January 2, 2026. ULP-B's personnel record lacked baseline TB screening that included assessment of TB history and current symptoms of active TB disease; and a two-step TST or other evidence of TB testing such as IGRA. ULP-B's personnel record lacked TB training upon hire. On April 1, 2026, at 1:25 p.m., licensed assisted living director (LALD)-C confirmed ULP-A's personnel record was missing TB test results; and ULP-B was missing baseline TB screening. LALD-C stated the licensee did not provide TB training upon hire or annually as the licensee would only provide the licensee's TB policy to staff at the time of hire, which did not include education material on TB. The licensee's undated Tuberculosis Screening policy indicated staff whose essential job function required work within the same air space of home care clients (residents, not home care clients) would be screened and tested for TB prior to staff being exposed to residents; and the baseline TB screening would be completed upon hire. Also,	0 660		

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0 660	Continued From page 12 the policy indicated staff would be educated regarding TB at the time of their hire on basic information about TB pathogenesis and transmission, signs and symptoms of active TB disease, and the licensee's infection control plan, especially any sections that the employee was responsible for implementing. The policy did not indicate TB training was required annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	0 680		

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0 680	Continued From page 13 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z; and failed to post the EPP prominently. 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 the potential to affect a large portion or all of the residents). The findings include: On March 31, 2026, at 11:09 a.m., during a facility tour, the surveyor did not observe the licensee's EPP posted prominently. The licensee's Emergency Preparedness/Disaster Plan dated July 1, 2025, lacked evidence of the following required content: - develop and maintain the EP; - maintain and annual EP updates; - EP program patient population; - process for EP collaboration; - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - policies and procedures including evacuation; - policies and procedures for sheltering;	0 680		

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0 680	Continued From page 14 - policies and procedures for medical documents; - policies and procedures for volunteers; - arrangement with other facilities; - roles under a wavier declared by secretary; - names and contact information; - emergency officials contact information; - methods for sharing information; - emergency prep training and testing; - emergency prep training program; and - emergency prep testing requirements. On April 1, 2026, at 4:14 p.m., licensed assisted living director (LALD)-C stated they recently updated the licensee's EPP, however the licensee did not have documentation of annual reviews of the EPP. LALD-C confirmed the licensee's EPP had missing content. The licensee's undated Emergency Preparedness/Disaster Plan policy indicated the licensee would maintain a response plan for handling emergency situations; and would ensure the safety and wellbeing of the community employees and residents during an event that may result in the interruption of resident care or services. The policy did not indicate it would include all the required elements of Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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:	0 775		

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0 775	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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, Physical Environment Inspection Report (PEIR) dated March 31, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for	0 780		

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0 780	Continued From page 16 sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not	0 780		

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0 780	Continued From page 17 found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 31, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=B	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level one violation (a violation that will cause only minimal impact on	0 790		

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0 790	Continued From page 18 the resident and does not affect 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). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 31, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 810 SS=E	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	0 810		

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0 810	Continued From page 19 readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 31, 2026, for the specific violations related	0 810		

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0 810	Continued From page 20 the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living	01470		

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01470	Continued From page 21 services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee received all required orientation topics to assisted living statutes before providing direct care services to residents for two of two unlicensed personnel ((ULP)-A, ULP-B). 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	01470		

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01470	Continued From page 22 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 the potential to affect a large portion or all of the residents). The findings include: ULP-A ULP-A was hired on May 6, 2024. On April 1, 2026, at 7:51 a.m., the surveyor observed ULP-A assist four residents with going to the dining room for breakfast that included assistance with toileting, dressing, standby assistance with ambulation, meal set up, and preparing beverages for residents. ULP-A's personnel record lacked evidence of orientation training that included an overview of Assisted Living Statutes; handling emergencies and using emergency services; Assisted Living Bill of Rights; handling of resident complaints that included reporting of complaints and where to report; consumer advocacy services; and review of types of assisted living services the employee would provide and provider's scope of license. On April 1, 2026, at 2:29 p.m., ULP-A stated they did not recall having been trained on the Assisted Living Bill of Rights, consumer advocacy services, the types of assisted living services the employee would provide, or the provider's scope of license during their orientation. Also, ULP-A stated they knew there were places that were skilled and more independent living communities but did not know the types of assisted living services or the provider's scope of license. ULP-A stated they did not recall being trained regarding handling emergencies. ULP-A stated when they	01470		

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01470	Continued From page 23 were hired, the licensee did not have a maintenance person, but they were shown where to find fire extinguishers and the spill kits. ULP-B ULP-B was hired on January 2, 2026. ULP-B's personnel record lacked evidence of orientation training that included an overview of Assisted Living Statutes; handling emergencies and using emergency services; Assisted Living Bill of Rights; handling of resident complaints that included reporting of complaints and where to report; consumer advocacy services; and review of types of assisted living services the employee would provide and provider's scope of license. On April 1, 2026, at 12:54 p.m., licensed assisted living director (LALD)-C stated the licensee kept binders throughout the facility for handling emergencies; and the licensee's maintenance person would then show new staff around the facility to meet the orientation training topic on handling emergencies and using emergency services. LALD-C confirmed ULP-A and ULP-B did not have training on assisted living bill of rights as this was not indicated on their education transcripts completed through the licensee. LALD-C stated they had educated staff on an older version of the Assisted Living Bill of Rights as they were not aware this had been updated. LALD-C stated they were not familiar with the orientation training topic for consumer advocacy services. LALD-C stated the licensee provided orientation training for handling resident complaints by reviewing the licensee's policy on grievances with staff but confirmed this was not in the employee's record; and could not confirm if this had been completed.	01470		

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01470	Continued From page 24 On April 1, 2026, at 2:54 p.m., LALD-C stated they had spoken to the license's corporate registered nurse educator regarding orientation training topics regarding the overview of assisted living Statutes and the review of types of assisted living services the employee would provide including the provider's scope of license, in which LALD-C stated they were told, in the facility, LALD-C would need to provide information about the services they offered. LALD-C confirmed they did not go over the different types of assisted living services. The licensee's undated Orientation of Staff and Supervisors policy indicated all employees must complete an orientation to assisted living licensing requirements and regulations before providing assisted living services. The policy indicated the materials and/or type of training would be documented for compliance; and included all of the required training topics per Statute. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01910 SS=F	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		

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EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

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01910	Continued From page 25 remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include quantity and names of staff and other individuals involved in the disposition of medications for two of two discharged residents (R1, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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 the potential to affect a large portion or all of the residents). The findings include: R1 R1's Discharge Care Plan dated October 20, 2025, indicated R1 was admitted on June 15, 2022, and discharged on October 20, 2025. R1's Discharge Care Plan indicated R1 received	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(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 26 medication services for the following medications: amlodipine, glipizide, levothyroxine, metformin, nitrofurantoin, Risperdal, semaglutide, sertraline, HurriCaine topical anesthetic, lorazepam, nitroglycerin, nystatin cream, tramadol, and Tylenol. R1's Discharge Care Plan included section, Med Disposition Summary, which indicated lorazepam 86 tablets, tramadol 5 tablets, and Tylenol 58 tablets were disposed of by Drug Buster due to R1's discharge. R1's record lacked evidence of documentation of disposition of medications to include 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 for the following medications: amlodipine, glipizide, levothyroxine, metformin, nitrofurantoin, Risperdal, semaglutide, sertraline, HurriCaine topical anesthetic, nitroglycerin, and nystatin cream. R4 R4's Discharge Care Plan dated January 9, 2026, indicated R4 was admitted on July 14, 2022, and discharged on January 9, 2026. R4's Discharge Care Plan indicated R4 received medication services for the following medications: acetaminophen, alendronate sodium, aspirin, calcium, clobetasol, donepezil, latanoprost, levothyroxine, loratadine, metoprolol tartrate, nystatin powder, protopic tacrolimus, simvastatin, Vanicream, vitamin D, Aquafor, biscodyl, clobetasol cream, and nitroglycerin. R4's Discharge Care Plan included section, Med Disposition Summary, but this was left blank. R4's record lacked evidence of documentation of disposition of medications to include the	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(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 27 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 for the following medications: acetaminophen, alendronate sodium, aspirin, calcium, clobetasol, donepezil, latanoprost, levothyroxine, loratadine, metoprolol tartrate, nystatin powder, protopic tacrolimus, simvastatin, Vanicream, vitamin D, Aquafor, biscodyl, clobetasol cream, and nitroglycerin. On March 31, 2026, at 2:48 p.m., clinical nurse supervisor (CNS)-D stated R1 had gone to the hospital; and the family had declined to pick up the medications in which they were all destroyed and not documented. CNS-D confirmed the licensee did not have medication disposition documented for R4. CNS-D stated the licensee was only documenting the disposition of narcotics as they were not aware they needed to complete a medication disposition for all medications. The licensee's undated Medication Disposal policy indicated any current medications being managed by the licensee must be provided to the resident when the resident's service plan ended or medication management services were no longer part of the service plan. The policy indicated the licensee must document in the resident's record the disposition of the medication to include the medication name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(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 28 (21) days	01910		
02040 SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(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
02040	Continued From page 29 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 31, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

EDGEWOOD EGF SENIOR LIVING
608 5TH AVENUE NW
East Grand Forks, MN 56721
Polk County
Parcel:

Phone:

License Info

License: HFID 30631

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1049261065
Inspection Type: Full - Single
Date: 4/1/2026 Time: 11:15 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: SEVERAL EMPLOYEES HAVE TAKE A FOOD SAFETY COURSE. PIC INSTRUCTED TO HAVE A DESIGNATED EMPLOYEE REGISTER WITH THE STATE TO RECEIVE THE CFPM CERTIFICATE. PIC INSTRUCTED TO POST THE CFPM CERTIFICATE AT THE ESTABLISHMENT.
Comply By: 4/1/2026 Originally Issued On: 4/1/2026

! **New Order: 3-100 Food Characteristics: unadulterated**
3-101.11 *Priority Level: Priority 1 CFP#: 13*
MN Rule 4626.0125 Remove all unsafe and adulterated foods from the premises.
COMMENT: IN THE DRY STORAGE AREA, THERE WAS A CAN OF FOOD WITH A BENT RIM AND A DENT ON THE SIDE OF THE CAN. PIC INSTRUCTED TO NOT SERVE FOOD FROM DENTED CANS.
Comply By: 4/1/2026 Originally Issued On: 4/1/2026

New Order: 3-300B Protection from Contamination: cross-contamination, eggs
3-302.12 *Priority Level: Priority 3 CFP#: 37*
MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.
COMMENT: IN THE DRY STORAGE AREA, THERE WAS A BULK CONTAINER OF SUGAR COOKIE MIX WITHOUT A LABEL. PIC INSTRUCTED TO LABEL THE CONTAINER ACCORDINGLY.
Comply By: 4/1/2026 Originally Issued On: 4/1/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: PIC INSTRUCTED TO OBTAIN A DISH MACHINE THERMOMETER TO REGULARLY CHECK THE UTENSIL SURFACE TEMPERATURE.
Comply By: 4/1/2026 Originally Issued On: 4/1/2026

Food & Beverage General Comment

INSPECTOR MET WITH ESTABLISHMENT REPRESENTATIVE AND MDH NURSE EVALUATOR.

INSPECTOR DISCUSSED WITH ESTABLISHMENT:

-MAINTAINING AN EMPLOYEE ILLNESS LOG
-VOMIT CLEAN UP PROCEDURE

THE MAIN KITCHEN THAT PREPS, COOKS, AND SERVES FOOD FOR THE ESTABLISHMENT HAS ALL ANSI CERTIFIED EQUIPMENT, TILE FLOORING, PAINTED CEILING, WOOD CABINETS, AND LAMINATE COUNTERTOPS.

THERE ARE TWO SERVING KITCHENS IN POD C AND E. BOTH SERVING KITCHENS HAVE LAMINATE COUNTERTOPS, VINYL FLOORING, WOOD CUPBOARDS, PAINTED CEILING, PAINTED WALLS, DOMESTIC FRIDGE, AND MICROWAVE. HOWEVER, POD C DOES HAVE A HIGH TEMP DISH MACHINE.

POD C DISH MACHINE AND THE MAIN KITCHEN DISH MAIN BOTH TESTED ABOVE 160 DEGREES F UTENSIL SURFACE TEMPERATURE, INDICATING THAT THE DISHES AND UTENSILS ARE PROPERLY SANITIZED.

Things to Remember:

1. The Certified Food Manager should be routinely conducting self inspections to ensure that employees are following proper food handling practices.

2. Educate employees on the importance of reporting to management any illness they have or have had recently. Management should exclude any workers ill with vomiting or diarrhea from handling food, and they should keep an up to date employee illness log.

3. There should be a Person in Charge at the establishment during all hours of operation. This person should ensure that employees are practicing good hand washing procedures, including being knowledgeable about when hand washing should be done and how to properly wash hands.

4. Employees should use spatula, tongs, deli tissue, gloves, or some other approved means to prevent any direct bare hand contact with ready to eat foods.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Fergus Falls District Office inspection report number F1049261065 from 4/1/2026

Stephanie Reynolds

Establishment Representative

Stephanie Reynolds,
Public Health Sanitarian 2
218-332-5179
stephanie.reynolds@state.mn.us

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537

Temperature Observations/Recordings

Establishment Info

EDGEWOOD EGF SENIOR LIVING
East Grand Forks
County/Group: Polk County

Inspection Info

Report Number: F1049261065
Inspection Type: Full
Date: 4/1/2026
Time: 11:15 AM

Food Temperature: Product/Item/Unit: Chocolate Milk**; Temperature Process:** Cold-Holding
Location: Pod C Fridge at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Broccoli**; Temperature Process:** Cold-Holding
Location: Pod E Fridge at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Hamburger Gravy**; Temperature Process:** Hot-Holding
Location: Steam Table at 200 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Mashed Potatoes**; Temperature Process:** Hot-Holding
Location: Steam Table at 146 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Green Beans**; Temperature Process:** Hot-Holding
Location: Steam Table at 202 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Homemade Pizza Sauce**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 35 Degrees F.
Comment:
Violation Issued?: No

Fergus Falls District Office
Minnesota Department of Health
2314 College Way
Fergus Falls , MN 56537

Sanitizer Observations/Recordings

Establishment Info

EDGEWOOD EGF SENIOR LIVING
East Grand Forks
County/Group: Polk County

Inspection Info

Report Number: F1049261065
Inspection Type: Full
Date: 4/1/2026
Time: 11:15 AM

Sanitizing Chemical: **Product:** Sink and Surface**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 700 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Pod C Dish Machine **Equal To** 162.1 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Main Kitchen Dishwashing Area **Equal To** 170.4 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30631016-0	**Date:** March 31, 2026
Facility Name: EDGEWOOD EAST GRAND FORKS SENIOR LIVING	
Facility Address: 608 5TH AVENUE NW, EAST GRAND FORKS, MN 56721	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments: Labeled fire doors with self-closing hinges were installed between each pod. These fire doors were held open with magnetic hardware that was not tied into the building fire alarm system.

3. Controlled egress locking systems shall have the capability of being unlocked from the fire command center, a nursing station, or other approved location. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments: During the building tour, the surveyor asked maintenance specialist (MS)-F if a remote button or switch was installed that would disengage the controlled egress locking system for the building and MS-F stated no.

4. Gates used as a component in a means of egress shall meet the same requirements for doors. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.2]

   Comments: Illuminated exit signs were installed above two doors exiting into the dementia care courtyard. This courtyard was enclosed by a fence with two gates leading to the public way. Locks were installed on both fence gates that were not tied into the building fire alarm system.

5. Extension cords and flexible cords shall not be a substitute for permanent wiring and shall be listed and labeled in accordance with UL 817. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5]

   Comments: In the mechanical room, an extension cord was used to supply power.

6. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

   Comments: During the building tour, maintenance specialist (MS)-F stated they did not know the age of the smoke alarms installed in resident units in pod E. MS-F removed the smoke alarm from the bracket in resident bedroom E8 and the date of manufacture stamped on the back was 2011.

7. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

   Comments: Gas fireplaces and gas fired mechanical equipment were installed in the building. A carbon monoxide detection system was not installed in the building and carbon monoxide alarms were not installed within ten feet of all resident bedrooms.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

   Comments: During the building tour, maintenance specialist (MS)-F stated they did not know if the smoke detector installed in resident sleeping room A1 would provide an audible alarm in the event of a fire. MS-F removed the smoke detector from the bracket, and the back of the detector indicated it was a smoke detector head without audible alarm.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Pattern **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments: Inspections were not recorded every month on the back of the tags attached to the portable fire extinguishers. During the facility tour, maintenance specialist (MS)-F explained the maintenance

person for this building left last fall and the licensee had been unable to hire a qualified replacement. Fire extinguisher inspections must be conducted and documented every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Pattern **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

   Comments: Numbers were posted at the doors for each resident sleeping room. The posted evacuation floor plans were lacking these resident room number labels. Resident room numbers are required to be included on the FSEP floor plan and correspond with the numbers installed at the resident room doors to provide efficient communication for exiting in the event of a fire or similar emergency.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments:
   - The licensee failed to develop all parts of the fire safety and evacuation plan (FSEP) with site specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. During an interview, maintenance specialist (MS)-F stated part of the FSEP was a template printed off the company's software platform.
   - The emergency contact list posted above the keypad in pod E was not accurately maintained. It listed the name of a maintenance technician who was no longer employed at this facility.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The fire safety and evacuation plans (FSEP) provided by the licensee failed to include evacuation procedures for the individualized unique needs of residents and lacked instructions on where this information was maintained.

4. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

   Comments: The surveyor requested records for evacuation drills completed between March 2025 and March 2026, from the licensee. Record review of the provided evacuation drill reports indicated one tornado drill had been completed in October 2025. No additional 2025 evacuation drill records were provided.

☒ **TAG IDENTIFICATION: 2040**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Twenty One (21) days

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1. An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and have a safety risk assessment performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm. [Minn. Stat. 144G.81 subd.1]

   Comments: The surveyor requested a safety risk assessment of the physical environment with mitigation factors from the licensee. This assessment was not provided. The licensee stated they thought the emergency preparedness hazard vulnerability assessment that had been completed met this statute requirement and had not conducted a physical environment safety risk assessment.