Electronically delivered

January 31, 2022

Administrator
Edgewood Virginia I Senior Living
705 17th Street North
Virginia, MN 55792

RE: Project Number(s) SL30738015

Dear Administrator:

On January 12, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on October 21, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the October 21, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on October 21, 2021, found not corrected at the time of the January 12, 2022 follow-up evaluation and subject to penalty assessment are as follows:

0970-Waivers Of Liability Prohibited-144.50 Subd. 5 = No Fine

The details of the violations noted at the time of this follow-up evaluation completed on January 12, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in §144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in §144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in

§144G.20.

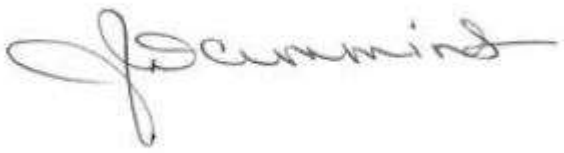
CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

We urge you to review these orders carefully. If you have questions, please contact Jeri Cummins at 218-302-6193.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,



Jeri Cummins, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 218-302-6193 Fax: 651-215-9697

pmb

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30738	A. BUILDING: _____ B. WING _____	R 01/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD VIRGINIA I SENIOR LIV	705 17TH STREET NORTH VIRGINIA, MN 55792

(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 Initial comments *****ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project SL#30738015 On January 12, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on October 21, 2021. At the time of the survey, there were 142 active residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following order was reissued.	{0 000}	Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
{0 970} SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor	{0 970}		

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{0 970}	Continued From page 1 include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On January 12, 2022, at approximately 1:30 p.m., a copy of the facility's contract was requested. The contract included a clause that indicated the "community is not liable to resident or resident's guests for any injury, death or property damage occurring in the apartment or on the community premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by resident or resident's guests." The contract further indicated "...resident agrees to hold the community harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment or on the community	{0 970}		

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{0 970}	Continued From page 2 premises." On January 12, 2022, at approximately 3:30 p.m., licensed assisted living director (LALD)-A confirmed the licensee's assisted living contract contained a waiver of liability. LALD-A stated they had consulted with the facility's attorney who reviewed the contract and language in the above-mentioned statute. E-mail correspondence dated November 17, 2021, at 11:02 a.m., stated they did not consider section 30 to be a waiver of liability for the health and safety of the resident or personal property of a resident. LALD-A stated based off that guidance, they did not make any adjustments to their contract. A policy on content of assisted living contracts was requested, but not provided. No further information was provided.	{0 970}		

Electronically Delivered

November 12, 2021

Administrator
Edgewood Virginia I Senior Liv
705 17th Street North
Virginia, MN 55792

RE: Project Number(s) SL30738015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 21, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance 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 imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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 issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days.

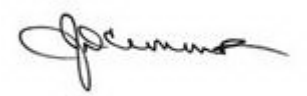
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jeri Cummins, Supervisor
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State Evaluation Team
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Email: jeri.cummins@state.mn.us
Telephone: 218-302-6193 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30738	A. BUILDING: _____ B. WING _____	10/21/2021

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EDGEWOOD VIRGINIA I SENIOR LIV	705 17TH STREET NORTH VIRGINIA, MN 55792

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders have been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#30738015 On October 18, 2021 through October 20, 2021 surveyors of this Department's staff, visited the above provider and the following correction orders were issued. At the time of the survey, there were 142 residents that were receiving services under the Assisted Living with Dementia Care license.	0 000		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's	0 460		

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0 460	Continued From page 1 visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a means for residents residing in the memory care building to request assistance for health and safety needs as required. The licensee did not have a system in place for residents at the facility to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all 38 residents residing in the secured memory care building. 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 and had a secured	0 460		

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0 460	Continued From page 2 memory care building. On October 18, 2021, at 1:05 p.m., Registered Nurse (RN)-B confirmed the facility did not have a call system in place for residents to request assistance when needed. Licensed Assisted Living Director (LALD)-A stated safety checks were conducted every 30 minutes in place of the call system. R4 R4's diagnoses included, but were not limited to, Alzheimer's dementia without behavioral disturbance, anxiety, and atrial fibrillation (an irregular, often rapid heart rate). R4 resided in the facility's secured building. Documentation on the facility's safety check log indicated checks were performed on October 19, 2021, at 0700 and 0730 by the unlicensed personnel. R4 was observed to have safety checks performed by the Licensed Practical Nurse (LPN)-D at 0710 and 0745. R4 confirmed she did not have a way to request assistance from staff between safety checks. R5 R5's diagnoses included, amnesia, hypothyroidism (underactive thyroid), and atrial fibrillation (an irregular, often rapid heart rate). R5 resided in the facility's secured building. Documentation on the facility's safety check log indicated checks were performed on October 19, 2021, at 7:00 a.m. and 7:30 a.m. by the unlicensed personnel. R5 was not checked by facility staff at 7:00 a.m. or 7:30 a.m., a safety check was conducted by unlicensed staff at 7:45 a.m. R5 confirmed he did not have a way to request assistance from staff between safety	0 460		

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0 460	Continued From page 3 checks. On October 19, 2021, at 12:05 p.m., LPN-D stated it would be her expectation that unlicensed staff perform safety checks every 30 minutes. LPN-D confirmed there was no other system in place for residents to request assistance if they needed something between the safety checks. On October 20, 2021, at approximately 10:00 a.m., RN-B stated it would be her expectation that staff performed safety checks every 30 minutes since the facility did not have a call system in place. The facility's policy, "Admission and Discharge Policy," dated August 2020, indicated residents in memory care were observed every 30 minutes for safety. The policy did not address how residents would request assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly	0 470		

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0 470	Continued From page 4 and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine its staffing level. This had the potential to affect all 142 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 facility with dementia care license. The facility was licensed for a resident capacity of 212 residents and had a	0 470		

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0 470	Continued From page 5 current census of 142 residents. During the entrance conference on October 18, 2021, at approximately 1:00 p.m., licensed assisted living director (LALD)-A stated the facility had not developed a written staffing plan, however stated the facility was staffed as follows: -the assisted living unit was staffed with six unlicensed personnel (ULP) on day and evening shifts and two-three ULP overnights; -the memory care unit was staffed with six ULP on day and evening shifts and two-three ULP overnights; -the campus was staffed seven days a week with a licensed practical nurse (LPN) from 6:00 a.m. to 10:30 pm.; and -the campus was staffed with registered nurses Monday through Friday 8:00 a.m. to 4:30 p.m. On October 18, 2021 at 2:15 p.m., registered nurse (RN)-B stated she had not developed a staffing plan, as required. RN-B was unable to describe how the campus determined staffing for each unit. A staffing policy was requested, although not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents:	0 480		

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0 480	Continued From page 6 (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared 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 included document titled, Food and Beverage Establishment Inspection Report dated September 27, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION:	0 480		

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EDGEWOOD VIRGINIA I SENIOR LIV	705 17TH STREET NORTH VIRGINIA, MN 55792

(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
0 480	Continued From page 7 Twenty-One (21) days	0 480		
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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency disaster plan with all the required content. This had the potential to affect all current residents, staff, and visitors.	0 680		

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0 680	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 18, 2021, at approximately 1:10 p.m., the surveyor requested to view the facility's emergency preparedness plan, which was received and later reviewed by the surveyor. The facility's plan lacked the following required content: - all hazards based emergency preparedness program with a risk assessment considering all hazards that may impact all or a portion of the facility; - an assessment of the at risk population's needs; - a process for emergency preparedness (EPS) cooperation with state and local EP officials/organizations; - development of all policies and procedures, based on risk assessment, and additional policies individualized to the facility for: potential evacuation, sheltering in place, handling medical documents and how the facility will provide care under an 1135 waiver declared by the Secretary; - a plan for sheltering in place when not able to	0 680		

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0 680	Continued From page 9 evacuate; - transfer agreements and/or contracts with other facilities/providers to receive residents in the event of evacuation or other limitations that would impact the continuity of services; - development of policies/procedures to address: - evacuation plan; - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information; - emergency staff strategies; - the facilities role in providing care and treatment at alternative sites; -how the facility will operate under an 1135 waiver; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management	0 680		

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0 680	Continued From page 10 agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and - a method of sharing information from the emergency plan with residents and their families On October 18, 2021, at approximately 2:35 p.m., licensed assisted living director (LALD)-A confirmed the licensee had not fully developed and implemented the facility's emergency preparedness plan. The licensee's policy, "Emergency & Disaster Response policy," dated December 1, 2015, did not address how the facility would ensure compliance with the required content in Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	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:	0 780		

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0 780	Continued From page 11 (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (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 and interview, the licensee failed to provide smoke alarms in locations that complied with fire protection requirements. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 19, 2021, between 10:00 a.m. and 12:50 p.m., engineering toured the facility with the	0 780		

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0 780	Continued From page 12 environmental services director (ESD)-J. During the tour of the main assisted living, building 705, it was observed that smoke alarms were not installed outside each separate sleeping area, in the immediate vicinity of bedrooms or in several resident dwelling units on the main floor. ESD-J stated that the apartments in building 705 were not all constructed at the same time. On October 19, 2021, ESD-J confirmed that smoke alarms were not provided outside each separate sleeping area, in the immediate vicinity of bedrooms or in resident apartments that were constructed during a specific time period. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain the physical environment in a continuous state of good repair and operation. This had the potential to directly affect all residents and staff.	0 800		

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0 800	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 19, 2021, between 10:00 a.m. and 12:50 p.m., engineering toured the facility with the environmental services director (ESD)-J. The following observations were made in the dementia care building 605: - one fire door was tied open with a plastic bag and a second fire door was propped open with a chair. - between rooms 2 and 4 in the A wing, a hallway designated as an exit escape was being used for storage. The stored items were blocking the path for egress escape. On October 19, 2021, ESD-J confirmed the fire doors should not have been propped open and exit hallways should not be used for storage. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 800		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or	0 900		

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0 900	Continued From page 14 provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute	0 900		

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0 900	Continued From page 15 a timely written contract to provide assisted living services for one of six residents (R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:. R6's diagnoses included, but were not limited to, cerebral infarction (a brain lesion in which a cluster of brain cells die when they don't get enough blood), metabolic encephalopathy (a disease that can cause episodes of metabolic crises and abnormal heart rhythms), multinodular goiter (abnormal enlargement of the thyroid gland that causes coughing, difficulty breating, hoarseness, and difficulty swallowing), and anxiety. R6's service plan dated September 24, 2021, indicated R6 received services, which included assistance with medication administration, transfers, bathing, hygiene, toileting and dressing. On October 18, 2021, at approximately 2:35 p.m., unlicensed personnel (ULP)-E was observed providing transfer assistance to R6. On October 19, 2021, at approximately 1:27 p.m., Registered Nurse (RN)-B confirmed a contract had not been developed or executed in a timely manner for R6 as required.	0 900		

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0 900	Continued From page 16 R6 records lacked a signed and executed timely written contract which included all of the terms concerning the provisions of the following as required: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. R6 records lacked evidence that the contract had been fully executed as the facility must: - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility	0 970		

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0 970	Continued From page 17 liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On October 18, 2021, at approximately 1:00 p.m., a copy of the the facility's contract was requested. The contract included a clause that indicated the "community is not liable to resident or resident's guests for any injury, death or property damage occurring in the apartment or on the community premises unless such injury, death or property damage occurs as the result of an equipment malfunction or hazardous conditions within the building not caused by resident or resident's guests." The contract further indicated "...resident	0 970		

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0 970	Continued From page 18 agrees to hold the community harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the apartment or on the community premises." On October 19, 2021 at approximately 10:00 a.m., licensed assisted living director (LALD)-A confirmed the licensee's assisted living contract contained a waiver of liability. A policy on content of assisted living contracts was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning	01470		

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01470	Continued From page 19 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 services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	01470		

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01470	Continued From page 20 Based on interview, observation and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations for one of six employees (unlicensed personnel (ULP)-F) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F's hire date was August 1, 2021. ULP-F's employee records lacked evidence to indicate ULP-F received orientation to include the following topics: - an overview of assisted living laws 144G; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;	01470		

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01470	Continued From page 21 - 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 - a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On October 19, 2021, at approximately 1:27 p.m., Registered Nurse (RN)-B confirmed ULP-F had not received the above noted required training. The licensee's Minnesota New Hire Orientation Checklist, revised July 2021 indicated all employees must complete orientation prior to providing assisted living services to residents to include: - overview of Minnesota's assisted living law; - introduction and review of the licensee's policies and procedures related to the provision of assisted living services; - emergency and disaster training; - the assisted living bill of rights; - principles of person-centered planning and service delivery; - types of assisted living services as indicated on the Uniform Disclosure of Assisted Living Services and Amenities and the licensee's scope of licensure; and - consumer advocacy services.	01470		

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01470	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure licensed staff conducted resident monitoring and review as	01620		

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01620	Continued From page 23 needed based on changes with resident needs for two of six residents (R6 and R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R6 R6's record did not include a re-assessment by a Registered Nurse (RN) following a return from urgent care with a diagnosis of acute bronchitis (A condition when the lining of the bronchial tube [the tube that carries air to and from the lungs] is inflamed. This causes cough with mucus, shortness of breath, and mild fever). R6's diagnoses included, but were not limited to, cerebral infarction (a brain lesion in which a cluster of brain cells die when they don't get enough blood), metabolic encephalopathy (a disease that can cause episodes of metabolic crises and abnormal heart rhythms), multinodular goiter (abnormal enlargement of the thyroid gland that causes coughing, difficulty breathing, hoarseness, and difficulty swallowing), and anxiety. R6's resident notes dated September 24, 2021, to October 24, 2021, indicated the following documentation in reference to the acute bronchitis change in condition:	01620		

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01620	Continued From page 24 - September 24, 2021, at 2:32 p.m., a Licensed Practical Nurse (LPN) documented in R6's record, "R6 was working with OT [occupational therapy] and therapist reports increased weakness. R6 reports coughing the night before. Sats stable but lower than normal @ 93% on RA. Crackles noted bilaterally. Family bringing to Urgent care to be assessed." - September 24, 2021, at 9:15 p.m., a LPN documented in R6's record, "resident returned from urgent care with diagnosis of acute bronchitis. Covid-19 swab negative. MD ordered a Z-pak. Family aware. RN notified via snap message." - October 24, 2021, at 8:01 a.m., a RN documented in R6's record, "resident completed antibiotics on September 28, 2021. Continues to have congestion. Sats at 96% on RA, afebrile." R6's resident notes indicated a re-assessment for change in condition had not been completed for R6 by a RN. R7 R7's record failed to include a re-assessment by an RN following notification to the RN by a LPN of changes in R6's skin condition. R7's diagnoses included, but were not limited to, anxiety, obesity, diabetes type II (condition results from insufficient production of insulin, causing high blood sugar), cognitive dysfunction (caused by abnormal levels of neurotransmitters such as substance P, serotonin, dopamine, norepinephrine, and epinephrine), schizoaffective disorder (mental disorder in which a person experiences a combination of symptoms of	01620		

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01620	Continued From page 25 schizophrenia and mood disorder). On August 25, 2021, R7 was evaluated at an emergency room (ER) and returned with a diagnosis of urinary tract infection (UTI). On September 7, 2021, R7 was evaluated at an ER and admitted to the hospital for chronic obstructive pulmonary disease (COPD) and pneumonia (infection of the air sacs in one or both the lungs characterized by severe cough with phlegm, fever, chills and difficulty in breathing). R7's resident notes dated August 1, 2021, to October 19, 2021, indicated the following documentation in reference to the UTI and COPD/pneumonia changes in condition: - August 25, 2021, at 12:05 p.m., a LPN wrote, "resident returned from ER . UTI. Macrobid (antibiotic) x 7 days with first dose given at the hospital per ER nurse." - September 7, 2021, at 12:13 p.m., a RN wrote, "received message from licensed practical nurse at Range Mental Health Center that resident was complaining of [sic] breath, with her sats being low. Registered Nurse directed Licensed Practical Nurse to send R7 to hospital. Transportation had left the mental health facility and had returned to licensee's site. Registered nurse met R7 in the parking lot,"sats at 85%, respirations 24, resident reports feeling short of breath." Registered nurse directed R7 be taken to the hospital. - September 7, 2021, at 5:21 p.m., LPN wrote, "resident admitted to hospital for COPD exacerbation and pneumonia and is currently starting on antibiotics."	01620		

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01620	Continued From page 26 - September 9, 2021, at 9:23 a.m., a RN wrote, "doing well and ready to come back. Currently on 1 liter per minute (LPM) of oxygen with sats of 95%. Has received IV (intravenous) antibiotics and was started on Prednisone." R7's resident notes dated August 1, 2021, to October 19, 2021, indicated a re-assessment for change in condition had not been completed for R7 by a RN . On October 19, 2021, at approximately 1:27 p.m., RN-B confirmed R6 and R7's record lacked a re-assessment by an RN following a change in condition. Licensee's Assessments policy, dated August 2020, indicated the RN responsibilities included conducting an assessment when a significant change in a resident's condition had occurred. Additionally, licensee's policy indicated that a change in condition is defined as - any deviation from the resident's typical clinical baseline. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current	01730		

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01730	Continued From page 27 individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication	01730		

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management record to include all required content for one of six residents (R7) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 October 18, 2021, at approximately 12:30 p.m., Registered Nurse (RN)-B confirmed the licensee provided medication management services to the majority of residents at the facility.

R7's diagnoses included, but were not limited to, anxiety, obesity, diabetes type II (condition results from insufficient production of insulin, causing high blood sugar), cognitive dysfunction (caused by abnormal levels of neurotransmitters such as substance P, serotonin, dopamine, norepinephrine, and epinephrine), schizoaffective disorder (mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder).

R7's service plan dated September 16, 2021, indicated R7 received medication management services.

R7's Medications Current as of October 18, 2021, included but was not limited to, the following medications: a mild pain reliever, three anti-depressants, one anti-anxiety, two anti-psychotics, one mood stabilizing, one

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01730	Continued From page 29 anti-hypertensive, one sleep aide, one medication to treat heartburn, three injectable insulins, one nebulizer inhalant, one bronchodilator inhaler, one steroid inhaler, two vitamins and as needed (PRN) narcotic pain medication. On October 19, 2021, at approximately 7:30 a.m., unlicensed personnel (ULP)-F was observed administering R7's morning medication. R7's medication management record did not include the following: - documentation of specific resident instructions relating to the administration of medications; - any resident-specific requirements relating to documenting medication administration, verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On October 19, 2021, at approximately 1:35 p.m., RN-B confirmed R7's individualized medication management plan failed to include all required content. Licensee's policy Medication Management Services dated February 2016 did not address individualized medication management plans. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 30 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 via manufacturer's instructions for one of six resident (R7) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R7 R7's diagnoses included, but were not limited to, anxiety, obesity, diabetes type II (condition results from insufficient production of insulin, causing high blood sugar), cognitive dysfunction (caused by abnormal levels of neurotransmitters such as substance P, serotonin, dopamine,	01760		

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norepinephrine, and epinephrine), schizoaffective disorder (mental disorder in which a person experiences a combination of symptoms of schizophrenia and mood disorder).

R7's service plan dated September 16, 2021, indicated R7 received medication management services.

R7's Medications Current - as of October 18, 2021, included, but was not limited to, Budesonide/formoterol 160-4.5 micrograms (mcg/act)(a combination of two medicines that are used to help control the symptoms of asthma and improve lung function) inhaler, inhale two puffs into the lungs two times a day and Incruze Ellipta 62.5 mcg/act (a medication that relaxes the muscles in the airways to improve breathing) inhaler, inhale one puff into the lungs one time a day.

October 19, 2021, at 7:45 a.m., the surveyor observed ULP-F shake the Budesonide/formoterol 160-4.5 micrograms (mcg/act) inhaler and handed it to R7. R7 took two puffs and returned the inhaler to ULP-F. At 7:46 a.m., ULP-F shook R7's Incruze Ellipta 62.5 mcg/act inhaler, handed it to R7; R7 inhaled one puff.

After exiting R7's room at approximately 7:50 a.m., the surveyor asked ULP-F if staff offered R7 assistance with rinsing her mouth following the administration of the steroid based inhaler (Budesonide/formoterol) and provided the opportunity to rinse her mouth between administration of the two inhalers. ULP-F verified staff did not offer assistance with rinsing her mouth or waiting the manufactures recommended wait time between administration

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01760	Continued From page 32 of the two inhalers. On October 19, 2021, at approximately 8:55 a.m., registered nurse (RN)-B confirmed ULP-F should have instructed R7 rinse her mouth following administration of a steroid based inhaler per manufacturers recommendations and it was the expectation ULP-F provided 3-4 minutes between administration of the two inhalers. The licensee's Medication Administration Manual dated October 2018, indicated unless otherwise instructed, the resident must wait at least one minute between puffs. When more than one inhaler is prescribed, the registered nurse would determine which inhaler to administer first. Additionally, licensees manual indicated a resident should rinse their mouth after use of a steroid inhaler to decrease the possibility of side effects, such as thrush (a fungal infection). 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 medications were stored according to manufacturer's	01880		

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01880	Continued From page 33 instructions for one of three medication refrigerators. 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 October 18, 2021, at approximately 1:10 p.m., Registered Nurse (RN)-B confirmed the licensee provided medication management services to the licensee's residents, including storage of medication. On October 18, 2021, at approximately 1:30 p.m., the memory care refrigerator was observed with RN-C. RN-C confirmed the refrigerator temperature to be 34 degrees Fahrenheit (F) and that daily refrigerator temperature monitoring was maintained in the facility's R-tasks documentation system. The refrigerator contained: - six unopened Novolog (short acting insulin) pens. The manufacturer's instructions for Novolog dated June 2021 indicated before opening store the insulin pens in the refrigerator (36-46 degrees Fahrenheit/F). Do not allow the Novolog to freeze. The Chore Recap Medication Refrigerator Temperature Log, from October 11, 2021, through	01880		

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01880	Continued From page 34 October 18, 2021, indicated the refrigerator temperature was not recorded four of eight days; and the temperature was out of range at 32 degrees F on one of four days and 34 degrees F on one of four days. The licensee's Medication Administration Policy dated August 2020 indicated all medications would be stored according to manufacturer's directions for light, humidity, temperature, or other storage instructions. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information, including the expiration date for time sensitive medications, for three of three residents (R7, R8, and R9) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01890		

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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:
On October 18, 2021, at approximately 1:15 p.m., a tour of the facility was conducted with licensed assisted living director (LALD)-A, including a review of the locked medication cart numbered three (3) with unlicensed personnel (ULP)-F. The following was observed, including but not limited to, and confirmed with ULP-F:
R7
R7's opened Ellipta 62.5 microgram (mcg) inhaler lacked an original prescription label with information regarding directions for use, medication name, medication dosage, resident's name, and the pharmacy where it was issued.
R8
R8's opened Ellipta 62.5 mcg inhaler lacked an original prescription label with information regarding directions for use, medication name, medication dosage, resident's name, and the pharmacy where it was issued.
R9
R9's opened Advair 250-50 milligram (mg) inhaler lacked an original prescription label with information regarding directions for use, medication name, medication dosage, resident's name, and the pharmacy where it was issued.
On October 18, 2021, at approximately 1:15 p.m., ULP-F confirmed all medications should have original prescription labels.
On October 19, 2021, at 10:00 a.m., Registered Nurse (RN)-B confirmed original prescription labels may be on boxes or bags, and medications should be retained in the original container

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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
01890	Continued From page 36 bearing the prescription label. The licensee's Medication Administration Policy dated August 2020 indicated how medications should be stored, however, did not address how medications were to be labeled. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; 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 facility failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. Mitigation of hazards to protect residents from harm was not included in the plan. This had the potential to affect all dementia care residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30738	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD VIRGINIA I SENIOR LIV	705 17TH STREET NORTH VIRGINIA, MN 55792

(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 37 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 19, 2021, between 10:00 a.m. and 12:50 p.m., engineering toured the facility with the environmental services director (ESD)-J. The following hazards or safety risks were observed in building 605 memory care: - gas fireplaces were located in common space living areas. Switches to turn on and off gas fireplaces were the same style as a single pole light switch. On October 19, 2021, ESD-J stated that gas fireplaces were used under staff supervision and were turned on and off using switches located on the wall; - one activity kitchen, located adjacent to a common area used by residents, was provided with a cooking range that included both a stove and oven. On October 19, 2021, at approximately 1:30 p.m., licensed assisted living director (LALD)-A confirmed the power supply to the cooking range had not been disconnected when kitchen staff were not present. On October 19, 2021, at approximately 1:45 p.m., LALD-A provided an electronic record of the Hazard Vulnerability Assessment for review. The	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30738	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD VIRGINIA I SENIOR LIV	705 17TH STREET NORTH VIRGINIA, MN 55792

(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 38 Hazard Vulnerability Assessment identified environmental hazards and safety risks within the community, but did not include hazards or safety risks on and around the property. Mitigation of these hazards was not included in the plan. On October 19, 2021, at approximately 1:55 p.m., LALD-A confirmed that the facility failed to include safety risks or hazards specific to the property on the hazard vulnerability assessment and mitigation of hazards to protect residents from harm was not included in the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30738	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD VIRGINIA I SENIOR LIV	705 17TH STREET NORTH VIRGINIA, MN 55792

(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
02110	Continued From page 39 of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 was licensed as an Assisted Living with Dementia Care facility.	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30738	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD VIRGINIA I SENIOR LIV	705 17TH STREET NORTH VIRGINIA, MN 55792

(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
02110	Continued From page 40 Review of the licensee's policies on October 19, 2021, indicated the licensee lacked the following required policies and procedures: - Evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; - Medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; - Limiting the use of public address and intercom systems for emergencies and evacuation drills only; - Transportation coordination and assistance to and from outside medical appointments; and - Safekeeping of residents' possessions. On October 20, 2021, at approximately 10:40 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the licensee had not developed the above required policies and procedures. The licensee's Dementia Disclosure Provision policy revised September 2017, indicated the provision would be provided to residents and their legal representatives and outlined the facility's approach to dementia care; however, the provision lacked the above policies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30738	A. BUILDING: _____ B. WING _____	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD VIRGINIA I SENIOR LIV	705 17TH STREET NORTH VIRGINIA, MN 55792

(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
02110	Continued From page 41 (21) days	02110		

Minnesota Department of Health
Food, Pools, & Lodging Services
P. O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/20/21*
Time: 10:20:00
Report: 7983211167

Food and Beverage Establishment Inspection Report

Location:
Edgewood Virginia I Senior Liv
705 17th Street North
Virginia, MN55792
St. Louis County, 69

Establishment Info:
ID #: 0037554
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2187417106
ID #:

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

The following orders were issued during this inspection.

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

3-305.11A

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

MEMORY CARE - SOME CANNED FOOD WAS STORED ON THE FLOOR IN THE STOREROOM.

Comply By: 10/27/21

6-200 Physical Facility Design and Construction

6-201.13A

MN Rule 4626.1345A Properly cove and seal the wall/floor junctures to no larger than 1/32 inch (1 millimeter).

ASSISTED LIVING: BASE COVE WAS MISSING FROM THE DAMAGED AREA OF WALL IN THE JANITOR'S CLOSET.

Comply By: 12/20/21

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

ASSISTED LIVING: A SMALL PORTION OF WALL AT THE FLOOR/WALL JUNCTURE IN THE JANITOR'S CLOSET WAS DAMAGED.

Comply By: 12/20/21

Surface and Equipment Sanitizers

Dodecylbenzenesulfonic Aci: = 700 at N/A Degrees Fahrenheit
Location: Wiping cloth bucket in the kitchen - ASSISTED LIVING.
Violation Issued: No

Dodecylbenzenesulfonic Aci: = 700 at N/A Degrees Fahrenheit
Location: Wiping cloth bucket in the warewashing room - MEMORY CARE.
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Warewashing Machine
Temperature: 152 Degrees Fahrenheit - Location: Wash water temperature - ASSISTED LIVING.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 194 Degrees Fahrenheit - Location: Rinse water temperature - ASSISTED LIVING.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 160 Degrees Fahrenheit - Location: Plate/utensil surface temperature - ASSISTED LIVING.

Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the walk-in freezer was frozen solid - ASSISTED LIVING.
Violation Issued: No

Process/Item: Walk-In Refrigerator
Temperature: 41 Degrees Fahrenheit - Location: Butter - ASSISTED LIVING.
Violation Issued: No

Process/Item: Walk-In Refrigerator
Temperature: 41 Degrees Fahrenheit - Location: Ham loaf - ASSISTED LIVING.
Violation Issued: No

Process/Item: Upright Refrigerator
Temperature: 40 Degrees Fahrenheit - Location: Butter in the Aurora double-door upright refrigerator - ASSISTED LIVING.
Violation Issued: No

Process/Item: Hot Holding
Temperature: 144 Degrees Fahrenheit - Location: Lasagna roll-up - ASSISTED LIVING.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 150 Degrees Fahrenheit - Location: Wash water temperature - MEMORY CARE.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 190 Degrees Fahrenheit - Location: Rinse water temperature - MEMORY CARE.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 160 Degrees Fahrenheit - Location: Plate/utensil surface temperature - MEMORY CARE.
Violation Issued: No

Process/Item: Upright Refrigerator
Temperature: 41 Degrees Fahrenheit - Location: Hard-boiled egg in the Turbo Air triple-door upright refrigerator - MEMORY CARE.
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -15 Degrees Fahrenheit - Location: Food in the Turbo Air double-door upright freezer was frozen solid - MEMORY CARE.
Violation Issued: No

Process/Item: Reheating
Temperature: 196 Degrees Fahrenheit - Location: Italian mix vegetables - MEMORY CARE.
Violation Issued: No

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

==========

GENERAL COMMENTS:

1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, and ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed.

2) Turkey roast is cooked/cooled. Pasteurized eggs are used.

3) Observed thawing under running water.

4) The certified food protection manager's certificate for Christen Combs was valid 6/1/2018 - 6/1/2021. MDH does not have evidence of renewal. Crystal Meyer is currently the certified food protection manager of record.

5) HRD staff were not available for discussion after the inspections were completed.

==========

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7983211167 of 10/20/21.

Certified Food Protection Manager: Crystal Meyer

Certification Number: FM100579 Expires: 08/22/22

Inspection report reviewed with person in charge and emailed.

Signed:_____ Signed: 7983

Christen Combs
Food Service Manager

651-201-4500
health.foodlodging@state.mn.us

Report #: 7983211167

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, & Lodging Services
P. O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	**Date**	10/20/21
No. of Repeat RF/PHI Categories Out	0	**Time In**	10:20:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

Edgewood Virginia I Senior Liv	**Address** 705 17th Street North	**City/State** Virginia, MN	**Zip Code** 55792	**Telephone** 2187417106
License/Permit # 0037554	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT		
PIC knowledgeable; duties & oversight			
2	IN OUT N/A		
Certified food protection manager, duties			
Employee Health			
3	IN OUT		
Mgmt/Staff;knowledge,responsibilities&reporting			
4	IN OUT		
Proper use of reporting, restriction & exclusion			
5	IN OUT		
Procedures for responding to vomiting & diarrheal events			
Good Hygenic Practices			
6	IN OUT N/O		
Proper eating, tasting, drinking, or tobacco use			
7	IN OUT N/O		
No discharge from eyes, nose, & mouth			
Preventing Contamination by Hands			
8	IN OUT N/O		
Hands clean & properly washed			
9	IN OUT N/A N/O		
No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed			
10	IN OUT		
Adequate handwashing sinks supplied/accessible			
Approved Source			
11	IN OUT		
Food obtained from approved source			
12	IN OUT N/A N/O		
Food received at proper temperature			
13	IN OUT		
Food in good condition, safe, & unadulterated			
14	IN OUT N/A N/O		
Required records available; shellstock tags, parasite destruction			
Protection from Contamination			
15	IN OUT N/A N/O		
Food separated and protected			
16	IN OUT N/A		
Food contact surfaces: cleaned & sanitized			
17	IN OUT		
Proper disposition of returned, previously served, reconditioned, & unsafe food			

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O		
Proper cooking time & temperature			
19	IN OUT N/A N/O		
Proper reheating procedures for hot holding			
20	IN OUT N/A N/O		
Proper cooling time & temperature			
21	IN OUT N/A N/O		
Proper hot holding temperatures			
22	IN OUT N/A		
Proper cold holding temperatures			
23	IN OUT N/A N/O		
Proper date marking & disposition			
24	IN OUT N/A N/O		
Time as a public health control: procedures & records			
Consumer Advisory			
25	IN OUT N/A		
Consumer advisory provided for raw/undercooked food			
Highly Susceptible Populations			
26	IN OUT N/A		
Pasteurized foods used; prohibited foods not offered			
Food and Color Additives and Toxic Substances			
27	IN OUT N/A		
Food additives: approved & properly used			
28	IN OUT		
Toxic substances properly identified, stored, & used			
Conformance with Approved Procedures			
29	IN OUT N/A		
Compliance with variance/specialized process/HACCP			

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30		IN OUT N/A		
Pasteurized eggs used where required				
31				
Water & ice obtained from an approved source				
32		IN OUT N/A		
Variance obtained for specialized processing methods				
Food Temperature Control				
33				
Proper cooling methods used; adequate equipment for temperature control				
34		IN OUT N/A N/O		
Plant food properly cooked for hot holding				
35		IN OUT N/A N/O		
Approved thawing methods used				
36				
Thermometers provided & accurate				
Food Identification				
37				
Food properly labled; original container				
Prevention of Food Contamination				
38				
Insects, rodents, & animals not present				
39	X			
Contamination prevented during food prep, storage & display				
40				
Personal cleanliness				
41				
Wiping cloths: properly used & stored				
42				
Washing fruits & vegetables				

			COS	R
Proper Use of Utensils				
43				
In-use utensils: properly stored				
44				
Utensils, equipment & linens: properly stored, dried, & handled				
45				
Single-use/single service articles: properly stored & used				
46				
Gloves used properly				
Utensil Equipment and Vending				
47				
Food & non-food contact surfaces cleanable, properly designed, constructed, & used				
48				
Warewashing facilities: installed, maintained, & used; test strips				
49				
Non-food contact surfaces clean				
Physical Facilities				
50				
Hot & cold water available; adequate pressure				
51				
Plumbing installed; proper backflow devices				
52				
Sewage & waste water properly disposed				
53				
Toilet facilities: properly constructed, supplied, & cleaned				
54				
Garbage & refuse properly disposed; facilities maintained				
55	X			
Physical facilities installed, maintained, & clean				
56				
Adequate ventilation & lighting; designated areas used				
57				
Compliance with MCIAA				
58				
Compliance with licensing & plan review				

Food Recalls:

Person in Charge (Signature) **Date:** 10/22/21

Inspector (Signature) 7983

Minnesota Department of Health
Food, Pools, & Lodging Services
P. O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *10/20/21*
Time: 10:20:00
Report: 7983211167

Food and Beverage Establishment Inspection Report

Location:
Edgewood Virginia I Senior Liv
705 17th Street North
Virginia, MN55792
St. Louis County, 69

Establishment Info:
ID #: 0037554
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2187417106
ID #:

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

The following orders were issued during this inspection.

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

3-305.11A

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

MEMORY CARE - SOME CANNED FOOD WAS STORED ON THE FLOOR IN THE STOREROOM.

Comply By: 10/27/21

6-200 Physical Facility Design and Construction

6-201.13A

MN Rule 4626.1345A Properly cove and seal the wall/floor junctures to no larger than 1/32 inch (1 millimeter).

ASSISTED LIVING: BASE COVE WAS MISSING FROM THE DAMAGED AREA OF WALL IN THE JANITOR'S CLOSET.

Comply By: 12/20/21

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

ASSISTED LIVING: A SMALL PORTION OF WALL AT THE FLOOR/WALL JUNCTURE IN THE JANITOR'S CLOSET WAS DAMAGED.

Comply By: 12/20/21

Surface and Equipment Sanitizers

Dodecylbenzenesulfonic Aci: = 700 at N/A Degrees Fahrenheit
Location: Wiping cloth bucket in the kitchen - ASSISTED LIVING.
Violation Issued: No

Dodecylbenzenesulfonic Aci: = 700 at N/A Degrees Fahrenheit
Location: Wiping cloth bucket in the warewashing room - MEMORY CARE.
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Warewashing Machine
Temperature: 152 Degrees Fahrenheit - Location: Wash water temperature - ASSISTED LIVING.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 194 Degrees Fahrenheit - Location: Rinse water temperature - ASSISTED LIVING.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 160 Degrees Fahrenheit - Location: Plate/utensil surface temperature - ASSISTED LIVING.

Violation Issued: No

Process/Item: Walk-In Freezer
Temperature: N/A Degrees Fahrenheit - Location: Food in the walk-in freezer was frozen solid - ASSISTED LIVING.
Violation Issued: No

Process/Item: Walk-In Refrigerator
Temperature: 41 Degrees Fahrenheit - Location: Butter - ASSISTED LIVING.
Violation Issued: No

Process/Item: Walk-In Refrigerator
Temperature: 41 Degrees Fahrenheit - Location: Ham loaf - ASSISTED LIVING.
Violation Issued: No

Process/Item: Upright Refrigerator
Temperature: 40 Degrees Fahrenheit - Location: Butter in the Aurora double-door upright refrigerator - ASSISTED LIVING.
Violation Issued: No

Process/Item: Hot Holding
Temperature: 144 Degrees Fahrenheit - Location: Lasagna roll-up - ASSISTED LIVING.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 150 Degrees Fahrenheit - Location: Wash water temperature - MEMORY CARE.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 190 Degrees Fahrenheit - Location: Rinse water temperature - MEMORY CARE.
Violation Issued: No

Process/Item: Warewashing Machine
Temperature: 160 Degrees Fahrenheit - Location: Plate/utensil surface temperature - MEMORY CARE.
Violation Issued: No

Process/Item: Upright Refrigerator
Temperature: 41 Degrees Fahrenheit - Location: Hard-boiled egg in the Turbo Air triple-door upright refrigerator - MEMORY CARE.
Violation Issued: No

Process/Item: Upright Freezer
Temperature: -15 Degrees Fahrenheit - Location: Food in the Turbo Air double-door upright freezer was frozen solid - MEMORY CARE.
Violation Issued: No

Process/Item: Reheating
Temperature: 196 Degrees Fahrenheit - Location: Italian mix vegetables - MEMORY CARE.
Violation Issued: No

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

==========

GENERAL COMMENTS:

1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, and ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed.

2) Turkey roast is cooked/cooled. Pasteurized eggs are used.

3) Observed thawing under running water.

4) The certified food protection manager's certificate for Christen Combs was valid 6/1/2018 - 6/1/2021. MDH does not have evidence of renewal. Crystal Meyer is currently the certified food protection manager of record.

5) HRD staff were not available for discussion after the inspections were completed.

==========

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 7983211167 of 10/20/21.

Certified Food Protection Manager: Crystal Meyer

Certification Number: FM100579 Expires: 08/22/22

Inspection report reviewed with person in charge and emailed.

Signed:_____ Signed: 7983

Christen Combs
Food Service Manager

651-201-4500
health.foodlodging@state.mn.us

Report #: 7983211167

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, & Lodging Services
P. O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	**Date**	10/20/21
No. of Repeat RF/PHI Categories Out	0	**Time In**	10:20:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

Edgewood Virginia I Senior Liv	**Address** 705 17th Street North	**City/State** Virginia, MN	**Zip Code** 55792	**Telephone** 2187417106
License/Permit # 0037554	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT		
PIC knowledgeable; duties & oversight			
2	IN OUT N/A		
Certified food protection manager, duties			
Employee Health			
3	IN OUT		
Mgmt/Staff;knowledge,responsibilities&reporting			
4	IN OUT		
Proper use of reporting, restriction & exclusion			
5	IN OUT		
Procedures for responding to vomiting & diarrheal events			
Good Hygenic Practices			
6	IN OUT N/O		
Proper eating, tasting, drinking, or tobacco use			
7	IN OUT N/O		
No discharge from eyes, nose, & mouth			
Preventing Contamination by Hands			
8	IN OUT N/O		
Hands clean & properly washed			
9	IN OUT N/A N/O		
No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed			
10	IN OUT		
Adequate handwashing sinks supplied/accessible			
Approved Source			
11	IN OUT		
Food obtained from approved source			
12	IN OUT N/A N/O		
Food received at proper temperature			
13	IN OUT		
Food in good condition, safe, & unadulterated			
14	IN OUT N/A N/O		
Required records available; shellstock tags, parasite destruction			
Protection from Contamination			
15	IN OUT N/A N/O		
Food separated and protected			
16	IN OUT N/A		
Food contact surfaces: cleaned & sanitized			
17	IN OUT		
Proper disposition of returned, previously served, reconditioned, & unsafe food			

Compliance Status		COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A N/O		
Proper cooking time & temperature			
19	IN OUT N/A N/O		
Proper reheating procedures for hot holding			
20	IN OUT N/A N/O		
Proper cooling time & temperature			
21	IN OUT N/A N/O		
Proper hot holding temperatures			
22	IN OUT N/A		
Proper cold holding temperatures			
23	IN OUT N/A N/O		
Proper date marking & disposition			
24	IN OUT N/A N/O		
Time as a public health control: procedures & records			
Consumer Advisory			
25	IN OUT N/A		
Consumer advisory provided for raw/undercooked food			
Highly Susceptible Populations			
26	IN OUT N/A		
Pasteurized foods used; prohibited foods not offered			
Food and Color Additives and Toxic Substances			
27	IN OUT N/A		
Food additives: approved & properly used			
28	IN OUT		
Toxic substances properly identified, stored, & used			
Conformance with Approved Procedures			
29	IN OUT N/A		
Compliance with variance/specialized process/HACCP			

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30		IN OUT N/A		
Pasteurized eggs used where required				
31				
Water & ice obtained from an approved source				
32		IN OUT N/A		
Variance obtained for specialized processing methods				
Food Temperature Control				
33				
Proper cooling methods used; adequate equipment for temperature control				
34		IN OUT N/A N/O		
Plant food properly cooked for hot holding				
35		IN OUT N/A N/O		
Approved thawing methods used				
36				
Thermometers provided & accurate				
Food Identification				
37				
Food properly labled; original container				
Prevention of Food Contamination				
38				
Insects, rodents, & animals not present				
39	X			
Contamination prevented during food prep, storage & display				
40				
Personal cleanliness				
41				
Wiping cloths: properly used & stored				
42				
Washing fruits & vegetables				

			COS	R
Proper Use of Utensils				
43				
In-use utensils: properly stored				
44				
Utensils, equipment & linens: properly stored, dried, & handled				
45				
Single-use/single service articles: properly stored & used				
46				
Gloves used properly				
Utensil Equipment and Vending				
47				
Food & non-food contact surfaces cleanable, properly designed, constructed, & used				
48				
Warewashing facilities: installed, maintained, & used; test strips				
49				
Non-food contact surfaces clean				
Physical Facilities				
50				
Hot & cold water available; adequate pressure				
51				
Plumbing installed; proper backflow devices				
52				
Sewage & waste water properly disposed				
53				
Toilet facilities: properly constructed, supplied, & cleaned				
54				
Garbage & refuse properly disposed; facilities maintained				
55	X			
Physical facilities installed, maintained, & clean				
56				
Adequate ventilation & lighting; designated areas used				
57				
Compliance with MCIAA				
58				
Compliance with licensing & plan review				

Food Recalls:

Person in Charge (Signature) **Date:** 10/22/21

Inspector (Signature) 7983