Electronically Delivered

September 3, 2025

Licensee
Edgewood May Creek LLC
303 10th Street South
Walker, MN 56484

RE: Project Number(s) SL30760016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 16, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the

correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30760	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MAY CREEK LLC	303 10TH STREET SOUTH WALKER, MN 56484

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30760160 On July 14, 2025 through July 16, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 43 residents; 42 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=D	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the staffing schedule was posted as required. This had the potential to affect all residents, staff, and visitors in one on two buildings (secured unit). 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	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living facility with dementia care license. The facility was licensed for a capacity of 49 and had a current census of 43 residents, which included 17 residents residing in the secured unit. On July 7, 2025, at 11:01 a.m., during the entrance conference licensed assisted living director (LALD)-A stated the facility posted daily staffing schedules for the residents in central locations; in the assisted living (non-secured) and at the cottage (secured unit). On July 7, 2025, at 1:26 p.m., during a tour of the secured unit with clinical nurse supervisor (CNS)-C, the surveyor did not observe the daily staffing schedule posted. CNS-C stated it is usually up, but "not today." Shortly after this observation CNS-C stated she found the daily staffing posting, by the time clock (positioned behind a locked door.) CNS-C confirmed the daily staffing schedule for the secured unit was not posted as required. The licensee's Staffing and Daily Schedule policy dated February 2022, noted the daily work schedule would be posted at the beginning of each shift in a central location in each building of the facility or campus accessible to staff, residents, volunteers, and the public. Per Assisted Living Facilities: Minnesota Rules	0 470		

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0 470	Continued From page 3 Chapter 4659.0180, Subp. 4, effective October 2022, the daily work schedule in item A must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by:	0 485		

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0 485	Continued From page 4 Based on observation and interview, the licensee failed to ensure weekly menus were made available to the residents in one of two buildings (secured unit). This had the potential to affect all 17 residents residing in the secured unit. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on July 14, 2025, at approximately 10:15 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-C stated the licensee provided three meals daily to include fresh fruits and vegetables, snacks were offered, residents had input with menus, and residents were made aware of changes to the menu. On July 14, 2025, at 1:24 p.m., during a tour of the secured unit with CNS-C, CNS-C stated the menu was normally on the refrigerator in the kitchen area of the secured building. CNS-C stated, no daily or weekly menus were posted in the secured unit as required. On July 15, 2025, at 9:45 a.m., LALD-A stated weekly menus were not normally posted in the secured unit. The licensee's Dining Services policy dated July 2024, noted weekly menus were posted.	0 485		

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0 485	Continued From page 5 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 640 SS=D	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required content in common areas, including posting the 911 emergency number in common areas and by telephones for resident use in the facility in one of two buildings (secured unit). This had the potential to affect 17 residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	0 640		

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0 640	Continued From page 6 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During a tour of the facility with licensed assisted living director (LALD)-A on July 14, 2025, at approximately 11:15 a.m., the surveyor observed the facility was separated into a non-secure unit and a secured unit. On July 14, 2025, at approximately 11:30 a.m., the surveyor did not observe 911 posted in any of the common areas or on or near telephones available for resident use, in the secured unit. LALD-A stated it was possible the 911 number was posted in the health office (area that was to be secured). LALD-A stated 911 was not posted as required in the secured unit of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled	0 660		

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0 660	Continued From page 7 volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) by not completing a TB risk assessment annually. 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) 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: During the entrance conference on July 14, 2025, at 11:07 a.m., licensed assisted living director (LALD)-A stated, "we just had this. (TB risk)" Clinical nurse supervisor (CNS)-C stated the risk level was low. The surveyor requested the facility's TB risk assessment. On July 14, 2025, at 2:55 p.m., the surveyor reviewed the facility's TB binder, which included a TB risk assessment dated June 3, 2019. The assessment noted the TB risk assessment would be conducted or updated, every two years. The surveyor asked if there was another TB risk	0 660		

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0 660	Continued From page 8 assessment for the facility. On July 16, 2025, at 9:02 a.m., LALD-A provided the surveyor with a TB risk assessment and stated she got the form from "Share Point." The TB risk assessment had not been completed. LALD-A stated she was confused, she thought the surveyor had previously requested TB screenings. CNS-C stated she was not aware the TB risk assessment needed to be completed yearly. CNS-C added the name on the TB risk assessment also needed to be updated for the "in charge" person. CNS-C confirmed the TB risk assessment for the facility was not completed yearly as required. The Minnesota Department of Health (MDH) guidelines "Regulations for Tuberculosis Control in Minnesota Health Care Settings" dated February 3, 2022, and based on CDC guidelines, indicated a TB risk assessment should be completed on an annual basis. The licensee's undated Tuberculosis Screening policy noted the facility would maintain a current community TB risk assessment. The assessment would be updated annually, using the data and form provided by the Minnesota Department of Health. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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0 680	Continued From page 9 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan (EPP) posted in a prominent area and failed to post an exit diagram in two of two buildings (secured, non-secured). Further, the licensee failed to develop the EPP with all the required content. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 680		

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0 680	Continued From page 10 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: POSTED IN PROMINENT AREA During the entrance conference on July 14, 2025, at 11:09 a.m., licensed assisted living director (LALD)-A stated there were EPP binders in "both health offices." LALD-A stated there was not signage of where the facility's EPP was located in either building, assisted living (secured) or cottage (un-secured). On July 14, 2025, at 11:22 a.m., during a tour of the non-secured unit with LALD-A, the surveyor did not observe any signage of the location of the facility's EPP. On July 14, 2025, at 11:36 a.m., during a tour of the secured unit with LALD-A, the surveyor did not observe any signage of the location of the facility's EPP. Directly after the above observation LALD-A stated she was unaware of the requirement to post the EPP in a prominent area. DIAGRAMS On July 14, 2025, at 11:24 a.m., during a tour of the facility with LALD-A, the surveyor did not observe a diagram of the facility on the main level or on the second level of the non-secured unit. LALD-A stated the facility was in a small town and everyone knew everyone, including the fire department.	0 680		

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0 680	Continued From page 11 On July 14, 2025, at 11:36 a.m., during a tour of the secured unit with LALD-A, the surveyor did not observe an exit diagram. LALD-A stated the exit diagrams were not posted on either level of the non-secured unit, or in the secured unit. LALD-A stated "they" (management) made us (licensee) take them (diagrams) down to get professional ones made. LALD-A confirmed the licensee did not have exit diagram posted as required. CONTENT On July 16, 2025, at 10:16 a.m., the surveyor reviewed the facility's EPP dated June 25, 2025, with LALD-A. The facility's EPP did not include: - identification of the at-risk population. On July 16, 2025, at 10:29 a.m., LALD-A stated the facility's EPP did not identify the population at risk. The licensee's undated Emergency Preparedness policy noted it is the intent that (name of licensee) has in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix-Z. The emergency preparedness plan would include all required elements of appendix Z. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section	0 680		

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	30760	A. BUILDING: _____ B. WING _____	07/16/2025

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0 680	Continued From page 12 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with the Minnesota Fire Code. The deficient conditions have the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 775		

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0 775	Continued From page 13 On facility tour with director of maintenance (DM)-E on July 15, 2025, between 9:00 a.m. and 12:30 p.m. the following deficient conditions were observed: DEMENTIA CARE BUILDING: LOCKING: The surveyor observed there was a not a switch/key in the dementia care wing that released all the doors. There shall be a key/switch that unlocks all the doors and the outside gate in the dementia care building. The gate lock shall be verified that is opens under fire alarm conditions. FIRE ALARM SYSTEM: The surveyor observed two mechanical rooms that had fire alarm devices missing. Verify these devices should be installed. FIRE RATED WALLS: The surveyor observed a hole in the fire rated wall in room next to the salon and under the steps in the lower level. All fire rating of walls and ceilings shall be maintained. ASSISTED LIVING BUILDING: FIRE SPRINKLER SYSTEM MONITORING: The surveyor observed the fire alarm/sprinkler	0 775		

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0 775	Continued From page 14 system was not being monitored. For existing sprinkler systems, monitoring is required when the number of sprinklers is 100 or more. FIRE ALARM SYSTEM: The surveyor observed a fire alarm device missing in the attached garage. Verify this device should be installed. KITCHEN HOOD PROTECTION SYSTEM: During record review of the kitchen hood extinguishing system annual report, it was noted that the 12-year hydro static test was due. This shall be completed. FIRE-RESISTANCE RATED CORRIDORS: The surveyor observed kick down hold opens on the bottom of many fire rated doors opening to the corridors, a fire rated door was removed in the basement and storage in the north stairwell. All fire rated doors with closures to the corridor shall close and latch automatically. This includes all resident rooms doors, laundry/mechanical/storage room doors and doors held open on hold open devices. The kick down devices shall be removed. The fire rated door in the basement that was removed shall be reinstalled and it shall close and latch automatically. No combustible storage is allowed in corridors or exit stairs. CARBON MONOXIDE:	0 775		

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0 775	Continued From page 15 The surveyor observed that there were carbon monoxide alarms not in the correct area. Carbon monoxide protection shall be provided as required by the Minnesota State Fire Code. EXTENSION CORDS: The surveyor observed an orange and cream extension cord in the Activity Directors Office being used permanently. Extension cords shall not be used for permanent use. FIRE RATED WALLS: The surveyor observed a hole in the fire rated wall in the mechanical room in the basement. All fire rating of walls and ceilings shall be maintained. ELECTRICAL: The surveyor observed a cover missing on the electrical receptacle by the water softener in the basement. Approved covers shall be provided for all switch and electrical outlet boxes. The deficient conditions were visually verified by the DM-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		

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01440	Continued From page 16	01440		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for two of three employees (unlicensed personnel (ULP)-B, ULP-F). 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	01440		

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01440	Continued From page 17 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: ULP-B ULP-B was hired on May 29, 2025, to provide direct care services to residents of the facility. On July 14, 2025, at 2:13 p.m., the surveyor observed ULP-B administer R7's afternoon oral medication. ULP-B's employee record included a supervision of unlicensed personnel form dated (signed by ULP-B) September 13, 2024, (prior to ULP-B's hire date as a ULP) that noted: - communication with residents: blank - respect for resident's: blank - accurate documentation of services: blank - infection control/Standard precautions procedures followed: blank - specific delegated task (s)/skills observed: blank. ULP-B's employee record lacked documentation of a registered nurse (RN) supervising ULP-B performing a delegated task within 30 days of beginning work with the licensee. On July 16, 2025, at 8:47 a.m., business office director/ULP (BOD)/ULP-I stated, she was not sure what happened there (with ULP-B 's 30 day delegated task) form. BOD/ULP-I stated that was (name of another RN) and BOD/ULP-I did not	01440		

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01440	Continued From page 18 know if that (previous) RN forgot to sign the form? CNS-C agreed with BOD/ULP-I's comment. ULP-F ULP-F was hired on January 16, 2024, to provide direct care services to residents of the facility. On July 15, 2025, at 8:47 a.m., the surveyor observed ULP-F administer R6's morning medication using correct technique. ULP-F's employee record included a supervision of unlicensed personnel form dated February 18, 2024, that noted: - communication with residents: performance meets or exceeds standards - respect for resident's: performance meets or exceeds standards - accurate documentation of services: performance meets or exceeds standards - infection control/Standard precautions procedures followed: performance meets or exceeds standards - specific delegated task (s)/skills observed: blank ULP-F's employee record lacked documentation of a registered nurse (RN) supervising ULP-F performing a delegated task within 30 days of beginning work with the licensee. On July 16, 2025, at 8:58 a.m., ULP-F's 30-day supervision form was reviewed with LALD-A. LALD-A stated ULP-F's 30-day supervision form did not note a delegated task had been observed as required. CNS-C stated she was newer to the position of CNS and confirmed ULP-F's 30-day supervision form failed to identity a delegated task was supervised as required.	01440		

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01440	Continued From page 19 The licensee's Supervision of Licensed and Unlicensed Personnel policy dated September 2017, noted direct supervision unlicensed staff providing delegated nursing tasks, delegated treatments, or assigned therapy tasks must be performed within 30 days after the person begins work for our agency and has been trained and determined competent to perform all the tasks assigned. The RN would directly supervise staff performing delegated nursing tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01550 SS=D	144G.64 (a) (4) Training in Dementia, Mental Illness, and De- (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employees	01550		

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01550	Continued From page 20 that did not provide direct care, received at least four hours of initial training on dementia care within 160 working hours of the employment start date, for one of three employees, (dining assistant (DA)-G). 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: The licensee held an assisted living facility with dementia care license. The facility was licensed for a capacity of 49 and had a current census of 43 residents, which included 17 residents residing in the secured unit. The facility's staff roster noted DA-G was hired on March 19, 2024, as a full-time staff member. On July 15, 2025, at 8:06 a.m., the surveyor observed DA-G in the secured unit ask unlicensed personnel (ULP)-D who was administering medications for gloves to use in the dining area. DA-G's employee record included: -Teepa Snow (dementia training): Seeing it from the Other Side, dated March 22, 2024, 0.75 hours (45 minutes) -Teepa Snow: Teepa's GEMS, dated March 22, 0.25 hours (15 minutes) -Teepa Snow: Brain Changes dated March 22,	01550		

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01550	Continued From page 21 2024, 0.25 hours -Alzheimer's disease and Related Disorders-Communication Needs, dated March 22, 2024, one hour (60 minutes) -Alzheimer's Disease and Related Disorders: ADLs (activities of daily living) and Behaviors dated March 21, 2024, one hour. DA-G's dementia hours totaled 3.25 hours within 160 hours of start date. DA-G's record did not include four hours of dementia training completed within 160 hours of employment start date. On July 16, 2025, at 10:03 a.m., licensed assisted living director (LALD)-A reviewed DA-G's employee training record with the surveyor. LALD-A stated DA-G had also completed four hours of dementia training on May 30, 2025. LALD-A stated DA-G's dementia training was completed late, and 160 hours would be just after 60 days of employment. LALD-A confirmed DA-G had not completed the required hours of dementia training within the first 160 of DA-G's start date. The licensee's Minnesota Non-Direct Care Employees New Hire Orientation Relias (on-line training program) training hours document dated December 6, 2024, noted four hours of dementia training was required within 60 days of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01550		

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01640	Continued From page 22	01640		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans were revised to include provided services for one of three residents (R6). 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	01640		

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01640	Continued From page 23 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On July 14, 2025, at 10:52 a.m., during the entrance conference clinical nurse supervisor (CNS)-C stated the licensee provided medication set up services for two residents who took Coumadin (medication used to prevent and treat harmful blood clots). R6's diagnoses included deep vein thrombosis (DVT/ condition where a blood clot forms in a deep vein) of both lower extremities. R6's service plan dated May 29, 2025, indicated R6 received the following services: medication assist/ administration four times daily, protocol-anticoagulation three times daily, monthly vital sign monitoring, and housekeeping services. On July 14, 2025, at 1:13 p.m., the surveyor reviewed the contents of the non-secured assisted living medication cart with unlicensed personnel (ULP)-B. The surveyor observed a seven-day medication planner in R6's medication bin. ULP-B stated R6 was given medications from the seven-day medication planner (pre-set up medication). On July 15, 2025, at 8:47 a.m., the surveyor observed ULP-F administer R6's morning medication using correct technique. R6's assessment dated June 6, 2025, included: - personal history of other venous thrombosis and embolism - long term use of anticoagulants.	01640		

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01640	Continued From page 24 R6's medication administration record (MAR) dated July 1, 2025, through July 16, 2025, medication administered completion dated July 1, 2025, through July 14, 2025, included: - 10 milligrams (mg) Coumadin: Tuesday, Thursday, Saturday (July 1, July 3, July 5, July 8, July 10, July 12) - 10 mg, half tablets (5 mg) Coumadin : Monday, Wednesday, Friday, Sunday (July 2, July 4, July 6, July 7, July 9, July 11, July 13, July 14). R6's prescriber order dated July 1, 2025, noted the above orders. R6's record included nurses notes: - July 1, 2025: faxed orders received, confirm same dose Coumadin same recheck instructions. Medication trays filled - July 9, 2025: fax received from (name) anticoagulation clinic. Resident's INR 2.5 today. Continue same dose. Coumadin (10 mg on Tuesday, Thursday, and Saturday, five mg on all other days). Recheck INR on July 16, 2025. Medication profile updated and reminder for lab entered. On July 15, 2025, at 1:33 p.m., R6's service plan was reviewed with CNS-C. CNS-C stated she was not sure why the service of medication set up was not on R6's service plan. CNS-C reviewed another service plan (resident also had medication set up service completed). CNS-C stated the other resident's service plan included medication set up services. CNS-C confirmed R6's service plan was not revised to include service provided. The licensee's Service Plan policy dated August 2022, noted the service plan and any revisions	01640		

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01640	Continued From page 25 shall include a signature or other authentication by the licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. Service plans shall be revised, if needed, based on resident reassessments and monitoring. Services plans and any revisions or updates shall be entered into the resident's record including notice of change of fees when applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R6). 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	01770		

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01770	Continued From page 26 a large portion or all of the residents). The findings include: On July 14, 2025, at 10:52 a.m., during the entrance conference clinical nurse supervisor (CNS)-C stated the licensee provided medication set up services for two residents who took Coumadin (medication used to prevent and treat harmful blood clots). On July 14, 2025, at 1:13 p.m., the surveyor reviewed the contents of the non-secured assisted living medication cart with unlicensed personal (ULP)-B The surveyor observed a seven-day medication planner in R6's medication bin. ULP-B stated R6 was given medications from the seven-day medication planner (pre-set up medication). On July 15, 2025, at 8:47 a.m., the surveyor observed ULP-F administer R6's morning medication using correct technique. R6's diagnoses included deep vein thrombosis (DVT/ condition were a blood clot forms in a deep vein) of both lower extremities. R6's service plan dated May 29, 2025, indicated R6 received the following services: medication assist/ administration four times days, and protocol-anticoagulation three times daily. R6's assessment dated June 6, 2025, included: - personal history of other venous thrombosis and embolism - long term use of anticoagulants. R6's medication administration record (MAR) dated July 1, 2025, through July 16, 2025,	01770		

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01770	Continued From page 27 medication administered completion dated July 1, 2025, through July 14, 2025, included: -10 milligrams Coumadin (mg): Tuesday, Thursday, Saturday (July 1, July 3, July 5, July 8, July 10, July 12) -10 mg Coumadin half tablets (5 mg): Monday, Wednesday, Friday, Sunday (July 2, July 4, July 6, July 7, July 9, July 11, July 13, July 14). R6's prescriber order dated July 1, 2025, noted the above orders. R6's record included nurses notes: - July 1, 2025: faxed orders received, confirm same dose Coumadin, same recheck instructions. Medication trays filled - July 9, 2025: fax received form (name) anticoagulation clinic. Resident's INR 2.5 today. Continue same dose. Coumadin (10 mg on Tuesday, Thursday, and Saturday, five mg on all other days). Recheck INR on July 16, 2025. Medication profile updated and reminder for lab entered. R6's record lacked documentation of dates of medication set up, of name of medication, quantity of dose, times to be administered, and route of administration. On July 15, 2025, at 2:52 p.m., R6's record was reviewed with CNS-C. CNS-C stated nurse's notes documented the medication set up service. CNS-C added when she set up Coumadin, the note she normally wrote included additional information than what was reviewed in R6's record. CNS-C stated the notes she normally entered did not include all the required information. CNS-C stated medication set up documentation lacked required information, and it was a widespread issue.	01770		

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01770	Continued From page 28 The licensee's Medication Management policy dated June 2025, noted when the licensed nurse had completed setting up the medications into the dosage box, the set-up was documented on the MAR. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for four of four medication carts (Keston, Hawthorne, Cart One, Cart Two). 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	01890		

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01890	Continued From page 29 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 14, 2025, at approximately 11:00 a.m., during a tour of the facility with licensed assisted living director (LALD)-A, the surveyor and LALD-A observed and confirmed the following: SECURED UNIT TIME SENSITIVE MEDICATION KESTON - R3's opened latanoprost 0.005% (high eye pressure) eye solution lacked the date the eye solution was opened or expiration date. The manufacturer's instructions for latanoprost dated February 1, 2023, directed to discard within 4 weeks of opening. HAWTHORNE - R4's opened Combivent AER 20 micrograms (mcg).100 mcg inhaler (shortness of breath) included open date of June 19, 2025. R4's Combivent lacked the expiration date. Directly after the above observation LALD-A looked at R4's inhaler and stated the label noted the medication would expire on June 9, 2026, (date the unopened inhaler would expire). The manufacturer's instructions for Combivent dated June 30, 2025, noted expiration date, three months (90 days) after assembly of device. NON-SECURED UNIT On July 14, 2025, at 1:13 p.m., during a tour of the assisted living medication storage area with clinical nurse supervisor (CNS)-C, and unlicensed	01890		

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01890	Continued From page 30 personnel (ULP)-B the surveyor and CNS-C observed and confirmed the following in non-secured unit: MEDICATION CART ONE - R5's opened Lantus 100 milliliters (ml)/unit long acting) insulin dated July 14, (no year noted). R5's Lantus lacked the expiration date. Directly after the above observation ULP-B stated she was not aware medication required both an open and an expiration date for time sensitive medications. The manufacturer's instructions for Lantus pens dated 2022, noted after 28 days throw your opened Lantus pen away, even if it still had insulin in it. MEDICATION CART TWO PRESCRIPTION LABEL - two white tablets in a medication cup non labeled Directly after the above observation, ULP-B stated the white tablets were for R6 and were Tylenol (mild pain). ULP-B stated she should have "got rid" of the unused medication for R6. CNS-C added R6 was "a hard one (to locate resident for medication administration). CNS-C confirmed the medication in the cup should have been labeled or discarded. CNS-C confirmed four of four medication carts lacked required information required. The licensee's Medication Storage policy revised June 2025, noted all medications must be dated when opened and discarded on or prior to the expiration date. Expiration dates will be monitored to prevent outdated medications. In addition, medication was to meet regulations for medication storage.	01890		

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01890	Continued From page 31 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of three residents (R7) receiving treatments. This practice resulted in a level two violation (a	01950		

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01950	Continued From page 32 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's diagnoses included chronic pulmonary embolism (blockage of pulmonary arteries that occur when prior blood clots in vessels don't dissolve), lower leg edema, enlarged prostate, and renal insufficiency (kidney impairment). R7's service plan dated March 13, 2025, included "miscellaneous tasks". On July 14, 2025, at 2:13 p.m., the surveyor observed unlicensed personnel (ULP)-B take a cup of medication she had prepared into R7's room. ULP-B stated R7 "usually took the medications on "his own." R7's record included a nurse's note dated January 29, 2024, that noted: lymphedema compression garments demo (demonstration) and start of treatment today 9-10 a.m. Physical therapy consultant here from (name) with resident's compression boots and shorts for daily treatment. MD (medical doctor) order scanned to documents. Service placed in p.m.(evening). Numbers in resources. Folder left in resident's room. Staff will need to assist resident with putting on and taking off daily. Resident would like to start with legs only. Did both shorts and legs today. Should urinate prior to starting. Treatment takes 45 minutes to one hour. Physical	01950		

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01950	Continued From page 33 therapy consultant (name) demo'ed (demonstrated) putting boots on and staring compression machine. CNAs (certified nursing assist/ULP), licensed practical nurse (LPN), registered nurse (RN) and daughter (R7's) present. He (R7) advised to wear light pants under garments. Numbers left to call for trouble shooting. R7's prescriber order dated May 19, 2025, included miscellaneous tasks. R7's record included: miscellaneous tasks, daily, at p.m., (evening) - assist resident with applying lymphedema compression boots and/or shorts every evening for one hour. Assist resident taking off when one hour completed. Make sure is comfortable in recliner and had used bathroom before beginning. Have urinal by chair. R7's record did not include specific instruction to include the procedures for notifying a RN or appropriate licensed health profession when a problem arises with lymphedema compression garments. On July 15, 2025, at approximately 11:40 a.m., R7's record was reviewed with clinical nurse supervisor (CNS)-C. CNS-C stated R7's record lacked directions on what and when to report to nursing regarding lymphedema compression garments. The licensee's undated Delegation of Assisted Living Services policy noted a RN may delegate nursing services to a person who had successfully completed staff orientation, who had been trained in the service to be provided, and who had demonstrated to the RN the ability to	01950		

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01950	Continued From page 34 competently follow the procedures for the resident; In addition, the RN would include: - specify, in writing, specific instructions for each resident and document those instructions in the residents' record - communicate with the ULP about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02310 SS=E	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of supplies. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	02310		

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02310	Continued From page 35 The findings include: The assisted living held a dementia care license with a current census of 43 residents. During a tour of the facility with licensed assisted living director (LALD)-A on July 14, 2025, at approximately 11:15 a.m., the surveyor observed the facility was separated into a non-secure unit and a secured unit. SPA ROOM/MEDICATION CART STORAGE (non-secured unit) On July 14, 2025, at 11:21 a.m., during a tour of the facility with licensed assisted living director (LALD)-A the surveyor observed in an open spa room, where medication carts were also stored, near the spa tub was an opened spray bottle of Q.T: 5 (cleaner/label noted, Keep out of Reach of Children DANGER). Directly after the above observation LALD-A stated the Q.T:5 should not have been there, and she (LALD-A) would talk to "someone" about it (Q.T:5 unsecured). Q.T:5 Safety Data Sheet, dated July 21, 2021, noted: - do not breathe mist/vapors. Do not get in eyes, on skin, or on clothing. Do not taste or swallow. Avoid prolonged exposure. When using, do not eat, drink or smoke. Use only outdoors or in a well-ventilated area. Wear appropriate personal protective equipment. Wash hands thoroughly after handling. Wash contaminated clothing before reuse. Observe good industrial hygiene practices - store locked up. Store in tightly closed container - store in original container in areas inaccessible to children.	02310		

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02310	Continued From page 36 HEALTH OFFICE (non-secured unit) On July 14, 2025, at 2:12 p.m., the surveyor observed the door titled Health Office opened. The surveyor did not observe any staff in the Health Office or visible in the hallway. The surveyor observed a cart that had dressing supplies in drawers; and gloves, hand sanitizer, and an opened bottle of hydrogen peroxide 3% sitting on top of the cart. On July 14, 2025, at 2:18 a.m., the surveyor observed an un-identified resident walk down the hallway near the opened Health Office door. On July 14, 2025, at 2:20 p.m. clinical nurse supervisor (CNS)-C stated the bottle of hydrogen peroxide should not have been left out (should have been secured). Hydrogen peroxide Safety Data Sheet, dated September 9, 2024, noted: - harmful if swallowed - causes serious eye damage - wear eye protection/face protection - if swallowed: call a poison center/doctor if you feel unwell. SECURED UNIT On July 15, 2025, at 6:35 a.m., the surveyor entered the secured unit. The surveyor observed an unidentified ULP enter a resident's room. The surveyor observed two residents sitting in the common's area and the door to the laundry room open. Hanging on the laundry sink was an opened spray bottle of CDC-10 (clinging disinfectant cleaner). On July 15, 2025, at 6:43 a.m., the surveyor observed ULP-F return vital sign equipment to the medication room.	02310		

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02310	Continued From page 37 On July 15, 2025, at 6:47 a.m., the surveyor observed ULP-F enter the laundry room. ULP-F closed (secured) the laundry room when she exited the laundry room. On July 15, 2025, at 7:04 a.m., ULP-F stated it was not normal to leave the laundry room door open (unsecured), as there were chemicals in the laundry room. ULP-F stated she was in the middle of "swapping loads" (laundry) and someone (resident) fell. ULP-F stated she should have secured the laundry room door. On July 16, 2025, at approximately 11:15 a.m., CNS-C stated laundry rooms were to be secured, and doors locked when staff was not present. CDC-10 Safety Data Sheet, dated March 12, 2021, noted - danger, causes serious eye damage, causes skin irritation - wear protective gloves. Wear eye/face protection. Wear protective clothing. Wash hands and any exposed skin thoroughly after handling - keep container tightly closed in a dry, cool and well-ventilated place. Keep out of the reach of children. The Minnesota Bill of Rights dated November 8, 2022, noted residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. No further information was provided.	02310		

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02310	Continued From page 38 TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02320 SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the medication administration process was followed for one of three employees (unlicensed personnel (ULP)-B) for two of four residents (R7, R8). Further, the licensee failed to ensure a care plan was followed by one of three employees, (ULP-F) for R6. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: MEDICATION ADMINISTRATION	02320		

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02320	Continued From page 39 R7 R7's diagnoses included chronic pulmonary embolism (blockage of pulmonary arteries that occurs when prior blood clots in vessels don't dissolve), lower leg edema, enlarged prostate, and renal insufficiency (kidney impairment). R7's service plan dated March 13, 2025, indicated R7 received medication administration four times daily. R8 R8's diagnoses included depression, chronic pain, restless legs syndrome, and hypertension (high blood pressure/HTN). R8's service plan dated April 21, 2025, indicated R8 received medication administration eight times per day. R8's assessment dated April 21, 2025, included: - licensee staff to prepare and administer medications per MD (medical doctor) order - medication self-administration is not applicable: chooses for licensee staff to manage medications and administer. - medications administered by CMA (certified medication assistance), LPN (licensed practical nurse (LPN) or RN (registered nurse). ULP-B ULP-B was hired on May 29, 2025, to provide direct care and services to the licensee's residents (prior ULP-B had worked in food service). ULP-B's employee record included oral medication competency dated September 13, 2024.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30760	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MAY CREEK LLC	303 10TH STREET SOUTH WALKER, MN 56484

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02320	Continued From page 40 On July 14, 2025, at 2:13 p.m., the surveyor observed ULP-B take a cup of medication she had prepared into R7's room. ULP-B stated R7 "usually took medication on "his own". ULP-B left the medication cup with R7 and exited R7's room. Directly after the above observation ULP-B stated, "we (ULPs) just know who we need to stay with to observe medication administration. ULP-B added some residents are weak or have swallowing issues. ULP-B stated she made sure those (weak/swallowing issues) residents took their medication. ULP-B stated R8 was "another one (resident)" who "does it (medication administration)" by herself. ULP-B returned to the medication cart and documented R7's medication as administered. ULP-B reviewed R8's medication administration record (MAR) and prepared R8's medication. ULP-B took the prepared cup of medication to R8's room. ULP-B left the medication cup with R8. ULP-B exited R8's room. ULP-B did not observe R8 swallow the medication in the medication cup taken to R8's room. ULP-B returned to the medication cart and documented R8's medication as administered. On July 14, 2025, at 2:22 p.m., clinical nurse supervisor (CNS)-C stated ULP-B was not trained to administer medication "that way" (not to observe residents with medication administration). CNS-C added that is why "we" (staff/ULPs) are to carry the laptop with them when administering medication. CNS-C stated ULP-B would need some retraining. On July 14, 2025, at 2:29 p.m., CNS-C and the surveyor reviewed R7 and R8's medication assessments. CNS-C stated "maybe" R8's medication assessment could be updated, but it had not been, and medication administration	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30760	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MAY CREEK LLC	303 10TH STREET SOUTH WALKER, MN 56484

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02320	Continued From page 41 should have been observed by ULP-B. CARE PLAN R6 R6's diagnoses included deep vein thrombosis (DVT/ condition where a blood clot forms in a deep vein) of both lower extremities, fracture of second lumbar vertebra, fractures of ribs, essential tremor, and other specified disorders of bone density and structure. R6's service plan dated May 29, 2025, indicated R6 received the following services: medication administration four times daily, monthly vital sign monitoring, anticoagulation and skin -protocol three times daily, showers twice weekly, and housekeeping services. R6's assessment dated June 6, 2025, included: - dressing needs: no assistance needed with dressing and/or undressing - dressing needs-special: no special dressing needs - orders for physical therapy/occupational therapy (PT/OT). ULP-F ULP-F was hired on January 16, 2024, to provide direct care and services to the licensee's residents. ULP-F's employee file included documentation of last training dated May 31. 2024, for the Minnesota Nurse Aide registry (CNA/certified nursing assist). On July 15, 2025, at 8:54 a.m., the surveyor observed ULP-F assist R6. ULP-F stated, "I (ULP-F) have not put this (brace) on you (R6) before." ULP-F asked R6 if he would like the	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30760	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MAY CREEK LLC	303 10TH STREET SOUTH WALKER, MN 56484

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02320	Continued From page 42 brace over his shirt? ULP-F asked R6 which part was for the front (two-piece upper body brace with Velcro fasteners, three). R6 laid on his bed. ULP-F stated she would have put it on while R6 was standing up. ULP-F applied the back brace, then the front brace. ULP-F fastened the Velcro straps. ULP-F asked R6 how it felt. R6 asked ULP-F to adjust the Velcro straps. R6 stated ULP-F had been gone "for quite a while" on vacation. On July 15, 2024, at 11:36 a.m. CNS-C stated R6 was independent with body brace. CNS-C added R6 was still working with PT and she had not heard that R6 required assistance with upper body brace. CNS-C stated ULP-F went rouge while she assisted R6 with upper body brace. CNS-C stated R6's PT stated R6 was able to apply brace independently. The licensee's Medication Administration manual revised October 2018, included: -for oral medications, stay with the resident and ensure that the medication had been swallowed. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30760	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02410	Continued From page 43 (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure privacy was maintained for one of three residents (R9) while receiving services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30760	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MAY CREEK LLC	303 10TH STREET SOUTH WALKER, MN 56484

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02410	Continued From page 44 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R9's diagnoses included Alzheimer's dementia and diabetes. R9's service plan dated June 5, 2025, indicated R9 received blood glucose monitoring twice daily. R9's prescriber order dated August 2, 2024, included the above order. On July 15, 2025, at 7:24 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R9's oral medication in the open common's area/dining area. On July 15, 2025, at 7:34 a.m., the surveyor observed ULP-D gather blood glucose testing equipment to include a meter, testing strip, and alcohol pad. The surveyor observed R12 walking toward the common's area. On July 15, 2025, at 7:36 a.m., ULP-D went to where R9 was seated on the couch. ULP-D told R9, "hi, we are going to check your blood sugar (glucose), so you are going to have a poke (lancet used to collect a droplet of blood). ULP-D chose R9's left hand and cleaned R9's pointer finger with an alcohol pad. R10 asked ULP-D where she was to sit (as ULP-D assisted R9). ULP-D used the lancet, (R9 stated "ouchie, ouchie, ouchie"). ULP-D placed a testing strip into the meter and placed a drop of blood onto the testing strip to obtain a reading of 118. The surveyor did not observe ULP-D ask R9 to relocate or if it was ok that R9's blood glucose be checked in the common's area.	02410		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30760	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD MAY CREEK LLC	303 10TH STREET SOUTH WALKER, MN 56484

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02410	Continued From page 45 On July 15, 2025, at 816 a.m., ULP-D stated, "I am not going to lie to you." R9's blood glucose is checked where she (R9) is. ULP-D stated R9 is in R9's room "a lot." ULP-D stated she did not ask R9 to relocate or if it was ok to check blood glucose in common's area. ULP-D stated it made sense as "it is a privacy thing" to ask or encourage R9 to relocate or to test it in R9's room prior to R9 exiting R9's room. On July 15, 2025, at 11:47 a.m., clinical nurse supervisor (CNS)-C stated R9's blood glucose should have been checked in private. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. Residents have the right to respect and privacy regarding the resident's service plan. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for residents' safety or assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

EDGEWOOD MAY CREEK LLC

303 10TH STREET SOUTH

Walker, MN 56484
Cass County
Parcel:

Phone:

License Info

License: HFID 30760

Elizabeth Brown
Risk:
License:
Expires on:
CFPM: Mary Honer
CFPM #: 14401; Exp: 08/23/2025

Inspection Info

Report Number: F8046251053
Inspection Type: Full - Single
Date: 7/14/2025 Time: 12:51:03 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

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

I acknowledge receipt of the Bemidji District Office inspection report number F8046251053 from 7/14/2025

Zach Johnson

Mary Honer
Food Service Director

Zach Johnson,
Public Health Sanitarian
218-308-2108
zach.johnson@state.mn.us

Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Establishment Info

EDGEWOOD MAY CREEK LLC

Walker
County/Group: Cass County

Inspection Info

Report Number: F8046251053
Inspection Type: Full
Date: 7/14/2025
Time: 12:51:03 PM

Equipment Temperature: Product/Item/Unit: Low Boy**; Temperature Process:** Cold-Holding
Location: Memory Care at 40 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Fridge **; Temperature Process:** Cold-Holding
Location: Main kitchen at 40 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Reach In **; Temperature Process:** Cold-Holding
Location: Memory Care at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Salmon**; Temperature Process:** Hot-Holding
Location: Bain Marie at 150 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Green Beans**; Temperature Process:** Hot-Holding
Location: Bain Maire at 160 Degrees F.
Comment:
Violation Issued?: No

New Record: Product/Item/Unit: Entre & Sides**; Temperature Process:** Receiving
Location: Memory Care at 155+ Degrees F.
Comment: Items brought from main kitchen on cart.
Violation Issued?: No

Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Establishment Info

EDGEWOOD MAY CREEK LLC

Walker
County/Group: Cass County

Inspection Info

Report Number: F8046251053
Inspection Type: Full
Date: 7/14/2025
Time: 12:51:03 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Memory Care **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Main Kitchen **Equal To** 100 PPM
Comment:
Violation Issued?: No

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

Minnesota (MDH) Version
EH Manager; RPT: F8046251053

Food Establishment Inspection Report

Bemidji District Office
Minnesota Department of Health
705 5th St NW, Suite A
Bemidji, MN 56601

No. of Risk Factor/Intervention/Violations	0	Date: 7/14/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 12:51:03 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
EDGEWOOD MAY	303 10TH STREET SOUTH	Walker, MN	56484	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30760	Elizabeth Brown	Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions 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" or OUT 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	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
	Food Temperature Control			
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
	Food Identification			
37		Food properly labeled; original container		
	Prevention of Food Contamination			
38		Insects, rodents, & animals not present; no unauthorized person		
39		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 and used		
46		Gloves used properly		
	Utensils, 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		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Zach Johnson

Follow-up: Follow-up Date: