April 24, 2023

Licensee
Edgewood Baxter, LLC
14211 Firewood Drive
Baxter, MN 56425

RE: Project Number(s) SL30293015

Dear Licensee:

On April 17, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the January 20, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

*Kelly Thorson*

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 651-431-5000 Fax: 651-281-9796

PMB

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

Type: Follow-Up
Date: *04/17/23*
Time: 11:40:00
Report: 6808231103

# Food and Beverage Establishment Inspection Report



**Location:**
Edgewood Baxter LLC
14211 Firewood Drive
Baxter, MN56425
Crow Wing County, 18

**Establishment Info:**
ID #: 0017343
Risk: Medium
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**
Edgewood Baxter, LLC

Phone #: 2188284770
ID #: 46463

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

No NEW orders were issued during this inspection.

**Food and Equipment Temperatures**

Process/Item: Cold Holding
Temperature: 37-39 Degrees Fahrenheit - Location: lettuce, carrots, salad in undercounter unit
Violation Issued: No

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

**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 6808231103 of 04/17/23.

Certified Food Protection Manager: Michele Heilman

Certification Number: _____ Expires: 08/26/23

**Inspection report reviewed with person in charge and emailed.**

Signed: _____
Establishment Representative

Signed: Lee Ann Austin

Lee Ann Austin
Public Health Sanitarian
St. Cloud
320-223-7341
leeann.austin@state.mn.us

Electronically Delivered

February 22, 2023

Licensee
Edgewood Baxter LLC
14211 Firewood Drive
Baxter, MN 56425

RE: Project Number(s) SL30293015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 20, 2023, 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.

**LICENSING ORDERS**
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 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 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), 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:

**St - 0 - 0110 - 144g.10 Subdivision 1a - Assisted Living Director License Required - $500.00**
**St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration - $3,000.00**
**St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00**

**The total amount you are assessed is $6,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

**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 by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. 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 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 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 of the correction order receipt date.

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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

**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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

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,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30293 | A. BUILDING: _____ B. WING _____ | 01/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWOOD BAXTER LLC | 14211 FIREWOOD DRIVE BAXTER, MN 56425 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL30293015-0<br><br>On January 17, 2023, through January 20, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 67 residents, all of whom received services under the provider's Assisted Living with Dementia Care license.<br><br>An immediate correction order was identified on January 18, 2023, issued for SL30293015-0, tag identification 2310.<br><br>On January 19, 2023, the immediacy of correction order 2310 was removed, as verified by survey supervisor and surveyors on-site, however, non-compliance remained at a level 3, scope of pattern violation.<br><br>An immediate correction order was identified on January 19, 2023, issued for SL30293015-0, tag | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |

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| 0 000 | Continued From page 1<br>identification 1750.<br><br>On January 19, 2023, the immediacy of correction order 1750 was removed however, non-compliance remained at a level 3, scope of pattern violation. | 0 000 | | |
| 0 110 SS=F | 144G.10 Subdivision 1a Assisted living director license required<br><br>Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all of the licensee's residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>Licensed assisted living director (LALD)-H had a license effective through October 31, 2023; | 0 110 | | |

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| 0 110 | Continued From page 2<br>however, LALD-H's license listed the licensee as the Director of Record with BELTSS, with an expired "end date" of July 29, 2022.<br><br>On January 18, 2023, at 11:35 a.m., executive director (ED)-A stated LALD-H was only listed as the Director of Record until another LALD took over; however, stated she did not know what the process was when that LALD left that position. ED-A stated she would contact LALD-H to have this resolved.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 110 | | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(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:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced | 0 480 | | |

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| 0 480 | Continued From page 3<br>by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated January 17, 2023, for the specific Minnesota Food Code deficiencies.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 0 485 SS=C | 144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements<br><br>(13) offer to provide or make available at least the following services to residents:<br><br>(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:<br><br>(A) menus must be prepared at least one week in | 0 485 | | |

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| 0 485 | Continued From page 4<br>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;<br><br>(C) the facility cannot require a resident to include and pay for meals in their contract;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the Assisted Living contract did not require any resident to include and pay for meals as a part of their assisted living package fee for one of one resident (R5). This had the potential to affect all residents of the facility.<br><br>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).<br><br>The findings include:<br><br>On January 17, 2023, at 12:05 p.m., executive director (ED)-A provided a "survey binder" that included a blank Residency Agreement, revised March 2022, identified as the licensee's assisted living with dementia care contract, and ED-A indicated the documents in the binder were current. | 0 485 | | |

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| 0 485 | Continued From page 5<br><br>The Residency Agreement, page 3 of 23, section 6, titled Meal Plan, indicated the licensee offered a meal plan described in "Attachment C" that was included in the monthly base fee "by default," and indicated "You are not required to select or pay for the meal plan to live at the Community." The agreement gave the opportunity to opt out of the meal plan at any time and noted the resident would receive a corresponding credit against the monthly base fee, and directed the resident could sign and date "Attachment C." On page 20 of 23, a document titled "Attachment C Meal Plan Selection Form," indicated the licensee provided a meal plan with three nutritious meals and snacks available seven days per week, and noted in italics, "Please check below if you wish to opt out of the Community's meal plan. If you opt out of the meal plan, you will receive a corresponding reduction in monthly fees in the amount of $[blank] per month." The next line included a box with "No Meal Plan. I do not wish to participate in the meal plan offered by the Community at this time," to be checked by the resident if they were opting out of all meals.<br><br>R5 was admitted March 17, 2017, and began receiving services under the assisted living with dementia care license on August 1, 2021.<br><br>R5's Resident Agreement, revised January 2021, was signed by R5 on July 23, 2021, and by R5's legal representative on July 29, 2021. Although the licensee's current Resident Agreement had been revised in March 2022, R5's record lacked evidence of signing the licensee's current contract; however, the Meal Plan information had not changed. R5 and her legal representative signed "Attachment C" without checking the box, indicating R5 would be provided three meals and snacks, seven days per week. | 0 485 | | |

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| 0 485 | Continued From page 6<br><br>On January 18, 2023, at 7:57 a.m., unlicensed personnel (ULP)-F stated R5's routine included medication administration and blood glucose monitoring at around 10:30 a.m., each day, because R5 preferred to sleep in every day and never ate breakfast.<br><br>On January 19, 2023, at 12:05 p.m., ED-A and corporate nurse (CN)-C stated the Resident Agreement allowed the resident to either choose the meal plan with three meals, seven days per week, or they could choose to opt out and not receive any meals at all. CN-C stated there was not an option for a resident such as R5, to opt out of just one meal because it was included in the monthly cost whether they chose to eat all three meals or not.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 485 | | |
| 0 510 SS=E | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision. | 0 510 | | |

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| | 30293 | A. BUILDING: _____ B. WING _____ | 01/20/2023 |

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| 0 510 | Continued From page 7<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for one of one employee (unlicensed personnel (ULP)-F) observed to perform blood glucose testing.<br><br>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).<br><br>The findings include:<br><br>On January 18, 2023, at 10:30 a.m., the evaluator observed ULP-F preparing to check R5's blood glucose. ULP-F gathered the supplies out of the medication cart, and walked to R5's room. R5 was lying in bed. ULP-F donned gloves, cleansed R5's finger with an alcohol pad, used a lancet to poke the finger, and placed a drop of blood onto the testing strip in the device. ULP-F announced to R5 that her blood sugar result was 168. R5 sat up and, without removing the gloves ULP-F handed R5 the medication cup with oral medications. R5 took the medications with water. ULP-F removed the gloves and gathered the supplies. Without performing hand hygiene, ULP-F touched a cupboard door and a kitchen chair, left R5's room touching the door handle, | 0 510 | | |

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| 0 510 | Continued From page 8<br><br>and walked to the medication cart. ULP-F placed the lancet in the sharps container and unlocked the medication cart to put the glucometer into the drawer. ULP-F closed the drawer and used the hand sanitizer on top of the medication cart to perform hand hygiene.<br><br>When interviewed on January 18, 2023, at 10:47 a.m., ULP-F stated she usually tried to use the hand sanitizer outside of the residents' rooms, in the hallway, on her way back to the medication cart; however, stated she should probably perform hand hygiene before leaving the residents' rooms and before touching surfaces to prevent contamination.<br><br>On January 19, 2023, at 12:57 p.m., clinical nurse supervisor (CNS)-B stated hand hygiene should be performed promptly when removing gloves and before touching other surfaces.<br><br>The licensee's Gloves, Gowns, Masks policy, undated, directed gloves must be worn whenever there may be direct contact between any employee and contaminated objects, and indicated after use, gloves should be removed, disposed of in proper receptacle, and hands should be washed.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 550 SS=F | 144G.41 Subd. 7 Resident grievances; reporting maltreatment<br><br>All facilities must post in a conspicuous place information about the facilities' grievance | 0 550 | | |

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| 0 550 | Continued From page 9<br>procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to post required information related to the licensee's grievance procedure to include contact information for the individual responsible for handling resident grievances. This had the potential to affect all 67 residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On January 17, 2023, at 11:55 a.m., the evaluator observed the licensee's grievance procedure posted on a bulletin board in the hallway of the facility. The grievance procedure indicated the resident should direct his/her concern/problem to the Executive Director (ED) or the Clinical Services Director (CSD), who would take | 0 550 | | |

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| 0 550 | Continued From page 10<br><br>responsibility for involving others who could help resolve the conflict, and if the ED or CSD was unable to resolve the matter to the resident's satisfaction, the resident could direct his/her grievance to the Resident Council and/or the President of the licensee. The procedure lacked the name, telephone number, and email contact information for the ED and/or the CSD. The procedure included the regional vice president's (RVP) name, address (located in North Dakota), and telephone number; however, lacked the email contact, as required.<br><br>On January 17, 2023, at 12:05 p.m., executive director (ED)-A stated the grievance procedure did not include the required content and would need to be changed.<br><br>The licensee's undated Grievance and Complaint policy provided to the evaluators included information regarding employee grievances/complaints, rather than resident grievances/complaints.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 550 | | |
| 0 660 SS=D | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(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 | 0 660 | | |

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| 0 660 | Continued From page 11<br>and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed screen for active and latent TB for one of four employees (unlicensed personnel (ULP)-F).<br><br>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).<br><br>The findings include:<br><br>ULP-F's employee record lacked documentation of a complete two-step screening for active/latent TB.<br><br>ULP-F was hired on June 1, 2022, to provide direct care to residents at the facility. | 0 660 | | |

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| 0 660 | Continued From page 12<br><br>ULP-F's record included documentation of a negative tuberculin skin test (TST) on June 17, 2022, with a second TST administered on July 11, 2022, at 12:45 p.m.; however, was read only 24 hours later, July 12, 2022, at 12:45 p.m., rather than 48 to 72 hours later, as required.<br><br>On January 19, 2023, at 12:56 p.m., clinical nurse supervisor (CNS)-B stated ULP-F's second TST result was read too soon, and should not have been read until 48 to 72 hours after the skin test was administered.<br><br>The licensee's Mantoux (brand of TB solution) Skin Test-Procedure, dated April 2022, indicated the licensed nurse would administer one milliliter (ml) of the solution intradermally (under the skin) on the forearm, and a community licensed nurse must read the test within 48 to 72 hours after it is administered, interpret result, and record the result on the report.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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 | 0 680 | | |

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| 0 680 | Continued From page 13<br>emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing tenant residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review the licensee failed to have a written emergency preparedness plan with all the required content.<br><br>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).<br><br>The findings include:<br><br>On January 17, 2023, at 11:41 a.m., the evaluator observed executive director (ED)-A inform facility | 0 680 | | |

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| 0 680 | Continued From page 14<br>maintenance personnel of the whereabouts of the emergency preparedness plan; the plan was located in a red binder on the bookshelves of ED-A's office, labeled, "Emergency Operations Program and Plan Manual." The plan contained a flip chart of various emergency situations, including how staff should respond in the event of a bomb threat, power outage, fire, and missing person. The facility's policies contained direction on making an emergency plan and the policies listed various emergency situations (such as heat, several weather emergencies, emergency evacuations, plan activations); however, the procedures spelled out in the plan were generic, lacking specificity to the facility.<br><br>On January 19, 2023, at 9:04 a.m., the evaluator requested to view the licensee's emergency preparedness plan.<br><br>The licensee's plan lacked the following required content:<br>-annual update and drills;<br>-all hazards-based emergency preparedness program with a risk assessment considering all hazards that may impact all or a portion of the facility;<br>-an assessment of the at-risk population's needs;<br>-a process for emergency preparedness (EPS) cooperation with state and local EP officials/organizations;<br>-policies and procedures that are stored in a central place;<br>-subsistence needs for staff and residents during emergency situation;<br>-procedure for tracking staff and residents;<br>-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; and | 0 680 | | |

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| 0 680 | Continued From page 15<br><br>-a communication plan with the following required content: names and contact information for staff/entities providing services under an agreement, residents' physicians, other facilities, volunteers, federal, state, tribal, regional, and local emergency preparedness staff, state licensing and certification agency, Office of the State Long Term Care Ombudsman, other sources of assistance, a plan for communicating during an emergency, including primary and alternative means for communication, procedures for sharing medical information to maintain continuity of care, and procedures for sharing the emergency plan with family members and residents.<br><br>On January 19, 2023, at 8:46 a.m., ED-A stated she understood and knew the emergency preparedness plan required updating and needed work. ED-A verbalized that staff, residents and residents' families had not been trained and educated on the emergency preparedness plan and reported the plan was last updated in 2021. ED-A stated they had exercised past drills of fire and elopement only, not drills specific to the emergency preparedness plan.<br><br>The licensee's policy "Emergency Operations Program and Plan Manual," undated, directed the facility used an "all-hazards" approach for emergency planning and response, and indicated the plan was customized to the facility and incorporated the response strategies of the community. The policy directed training and testing, including drills and exercise, were to be performed quarterly to every six months for each individual shift of facility personnel.<br><br>No additional information was provided. | 0 680 | | |

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| 0 680 | Continued From page 16<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors.<br><br>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).<br>Findings include:<br><br>On a facility tour on January 17, 2023, at approximately 12:00 p.m. with director of maintenance (DM)-D, a recessed ceiling light was | 0 800 | | |

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| 0 800 | Continued From page 17<br>observed flickering near the exit door leading to the outdoor secured activity area in the dementia care unit.<br><br>It was also observed the exterior exit path leading through the outdoor secured activity area to the public way, from the marked exit door in the common dining room of the dementia care unit, was not maintained clear of ice and snow. Keeping this exterior exit path and the exterior door landings clear of ice and snow helps provide unobstructed exiting for occupants and access for emergency responders in the event of an emergency.<br><br>On the facility tour utility carts were observed obstructing the means of egress in the corridor near the director of maintenance office. Keeping this required means of egress clear of obstructions helps provide access to the exits for occupants during an emergency.<br><br>A broken closet door handle with sharp edges was observed in the living room of resident room 111.<br><br>On the facility tour storage was observed in the marked means of egress corridor across from resident room 102 . Keeping this required means of egress clear of obstructions helps provide access to the exits for occupants during an emergency.<br><br>A large hole caused by a water leak was observed in the fire resistant rated ceiling of the mechanical room next to the assisted living mailboxes.<br><br>Storage was observed in the clear space required for access to the electrical panels in the | 0 800 | | |

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| 0 800 | Continued From page 18<br>mechanical room next to the assisted living mailboxes.<br><br>A space heater was observed plugged into an electrical multi plug device in resident room 215. Space heaters are required to be used according to the manufactures listing and plugged directly into the building electrical outlet.<br><br>A power cord for a light was observed routed through the bi-fold door opening into the bedroom closet with risk of damage to the cord in resident room 224. Electrical appliances are required to be used according to the manufactures listing.<br><br>Several electrical multi plug devices were observed plugged together in the mechanical room that opens to the common area on second floor above the main entrance. Electrical multi plug devices are required to be used according to the manufactures listing.<br><br>These deficient conditions were visually verified by DM-D accompanying on the tour.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for | 0 810 | | |

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| 0 810 | Continued From page 19<br>residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.<br>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct the required evacuation drills. This had the potential to affect all staff, residents, and visitors.<br><br>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 | 0 810 | | |

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| 0 810 | Continued From page 20<br>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).<br><br>A record review and interview were conducted on January 17, 2023, at approximately 11:15 a.m. of documents provided by director of maintenance (DM)-D on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility.<br><br>Findings include:<br><br>Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility as follows:<br><br>Record review of the available documentation indicated that the fire safety and evacuation plan did not include a floor plan that includes location and number of resident rooms. The plan provided at the time of survey was not clear enough to read room numbers.<br><br>Record review of the available documentation indicated that the fire safety and evacuation plan did not include fire protection procedures for employees in the event of a fire or similar emergency.<br><br>Record review of the available documentation indicated that the fire safety and evacuation plan did not include fire protection procedures for residents in the event of a fire or similar emergency.<br><br>Record review of the available documentation | 0 810 | | |

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| 0 810 | Continued From page 21<br>indicated that the fire safety and evacuation plan did not include procedures for employees regarding resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br><br>Record review of the available documentation indicated that employees did not receive training on the facility fire safety and evacuation plan upon initial hire and twice per year thereafter.<br><br>Record review of the available documentation indicated that the licensee did not provide training at least once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation.<br><br>All deficiencies were verified by DM-D during the interview at approximately 11:15 a.m.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 810 | | |
| 0 900 SS=F | 144G.50 Subdivision 1 Contract required<br><br>(a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident.<br><br>(b) The contract must contain all the terms concerning the provision of:<br>(1) housing;<br>(2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and<br>(3) the resident's service plan, if applicable. | 0 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 30293 | A. BUILDING: _____ B. WING _____ | 01/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EDGEWOOD BAXTER LLC | 14211 FIREWOOD DRIVE BAXTER, MN 56425 |

| (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 |
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| 0 900 | Continued From page 22<br><br>(c) A facility must:<br>(1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and<br>(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.<br><br>(d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.<br><br>(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.<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of it's contract. This had the potential to affect all current residents.<br><br>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 | 0 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 0 900 | Continued From page 23<br>the residents).<br><br>The findings include:<br><br>The licensee began providing services under their assisted living facility with dementia care license on August 1, 2021.<br><br>On January 17, 2023, at 12:05 p.m., executive director (ED)-A provided a "survey binder" that included a blank Residency Agreement, revised March 2022, identified as the licensee's assisted living with dementia care contract, and ED-A indicated the documents in the binder were current.<br><br>On January 19, 2023, at 12:05 p.m., ED-A stated they could not verify that a complete unsigned copy of the contract had been provided to the Office of Ombudsman for Long-Term Care, as required.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 900 | | |
| 0 910 SS=C | 144G.50 Subd. 2 (a-b) Contract information<br><br>(a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility.<br>(b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of:<br>(1) the facility and contracted service provider when applicable;<br>(2) the licensee of the facility; | 0 910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 0 910 | Continued From page 24<br>(3) the managing agent of the facility, if applicable; and<br>(4) the authorized agent for the facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to execute a written contract with the required content for five of five residents (R2, R3, R4, R5, R6).<br><br>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 the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>The licensee began providing services under their assisted living facility with dementia care license on August 1, 2021.<br><br>On January 17, 2023, at 12:05 p.m., executive director (ED)-A provided a "survey binder" that included a blank Residency Agreement, revised March 2022, identified as the licensee's assisted living with dementia care contract, and ED-A indicated the documents in the binder were current.<br><br>R2, R3, R4, R5, and R6's written contract lacked the following required content:<br>-the contract must include in a conspicuous place and manner on the contract the Health Facility Identification (HFID) number of the facility; and<br>-the contract must include the name, the | 0 910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 0 910 | Continued From page 25<br>telephone number, and physical mailing address, which may not be a public or private post office box, of:<br>-the authorized agent for the facility.<br><br>R2 was admitted and began receiving assisted living with dementia care services on April 22, 2022.<br><br>R2's record included a Residency Agreement, revised January 2021, signed by R2's designated representative on April 22, 2022; however, R2's record lacked an assisted living with dementia care contract with the above required content.<br><br>R3 was admitted on June 14, 2021, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021.<br><br>R3's record included a Residency Agreement, revised January 2021, signed by R3's legal representative on June 25, 2021; however, R3's record lacked an assisted living with dementia care contract with the above required content.<br><br>R4 was admitted on August 3, 2020, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021.<br><br>R4's record included a Residency Agreement, revised January 2021, signed by R4's legal representative on July 29, 2021; however, R4's record lacked an assisted living with dementia care contract with the above required content.<br><br>R5 was admitted March 17, 2017, under the comprehensive home care license and began receiving assisted living with dementia care | 0 910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 0 910 | Continued From page 26<br>services on August 1, 2021.<br><br>R5's record included a Residency Agreement, revised January 2021, signed by R5's legal representative on July 29, 2021; however, R5's record lacked an assisted living with dementia care contract with the above required content.<br><br>R6 was admitted on June 15, 2021, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021.<br><br>R6's record included a Residency Agreement, revised January 2021, signed by R6's legal representative on August 1, 2021; however, R6's record lacked an assisted living with dementia care contract with the above required content.<br><br>On January 19, 2023, at 12:05 p.m., ED-A stated the licensee's contract had been revised in March 2022 to include the required content; however, she was not aware that she needed to provide the new contract to the existing residents at that time, therefore, R2, R3, R4, R5, and R6 had the previous contract that was missing the HFID number and included the contact information for the previous authorized agent whom was no longer employed by the licensee.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 910 | | |
| 0 930 SS=C | 144G.50 Subd. 2 (d-e; 1-4) Contract information<br><br>(d) The contract must include a description of the facility's complaint resolution process available to | 0 930 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 0 930 | Continued From page 27<br>residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.<br>(e) The contract must include a clear and conspicuous notice of:<br>(1) the right under section 144G.54 to appeal the termination of an assisted living contract;<br>(2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer;<br>(3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;<br>(4) the resident's right to obtain services from an unaffiliated service provider;<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to execute a written contract with the required content for five of five residents (R2, R3, R4, R5, R6).<br><br>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 the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>The licensee began providing services under their | 0 930 | | |

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| 0 930 | Continued From page 28<br>assisted living facility with dementia care license on August 1, 2021.<br><br>On January 17, 2023, at 12:05 p.m., executive director (ED)-A provided a "survey binder" that included a blank Residency Agreement, revised March 2022, identified as the licensee's assisted living with dementia care contract, and ED-A indicated the documents in the binder were current.<br><br>R2, R3, R4, R5, and R6's written contract lacked the following content:<br>-The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints.<br><br>R2 was admitted and began receiving assisted living with dementia care services on April 22, 2022.<br><br>R2's record included a Residency Agreement, revised January 2021, signed by R2's designated representative on April 22, 2022; however, R2's record lacked an assisted living with dementia care contract with the above required content.<br><br>R3 was admitted on June 14, 2021, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021.<br><br>R3's record included a Residency Agreement, revised January 2021, signed by R3's legal representative on June 25, 2021; however, R3's record lacked an assisted living with dementia care contract with the above required content. | 0 930 | | |

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|---|---|---|---|---|
| 0 930 | Continued From page 29<br><br>R4 was admitted on August 3, 2020, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021.<br><br>R4's record included a Residency Agreement, revised January 2021, signed by R4's legal representative on July 29, 2021; however, R4's record lacked an assisted living with dementia care contract with the above required content.<br><br>R5 was admitted March 17, 2017, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021.<br><br>R5's record included a Residency Agreement, revised January 2021, signed by R5's legal representative on July 29, 2021; however, R5's record lacked an assisted living with dementia care contract with the above required content.<br><br>R6 was admitted on June 15, 2021, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021.<br><br>R6's record included a Residency Agreement, revised January 2021, signed by R6's legal representative on August 1, 2021; however, R6's record lacked an assisted living with dementia care contract with the above required content.<br><br>On January 19, 2023, at 12:05 p.m., ED-A stated the licensee's contract had been revised in March 2022 to include the required content; however, she was not aware that she needed to provide the new contract to the existing residents at that time, therefore, R2, R3, R4, R5, and R6 had the | 0 930 | | |

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| 0 930 | Continued From page 30<br>previous contract that included a description of the facility's complaint resolution process available to residents; however, included the incorrect name and contact information of the person representing the facility that was designated to handle and resolve complaints. That person was no longer employed by the licensee.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 930 | | |
| 0 950 SS=F | 144.50 Subd. 3 Designation of representative<br><br>(a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract:<br><br>"RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.<br><br>You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."<br><br>(b) The contract must contain a page or space for the name and contact information of the | 0 950 | | |

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| 0 950 | Continued From page 31<br>designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for five of five residents (R2, R3, R4, R5, R6).<br><br>This practice resulted in a level two violation (a violation that did not harm a client'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 clients).<br><br>The findings include:<br><br>The licensee began providing services under their assisted living facility with dementia care license on August 1, 2021.<br><br>On January 17, 2023, at 12:05 p.m., executive director (ED)-A provided a "survey binder" that included a blank Residency Agreement, revised March 2022, identified as the licensee's assisted living with dementia care contract, and ED-A indicated the documents in the binder were current.<br><br>R2, R3, R4, R5, and R6's written contract lacked | 0 950 | | |

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| 0 950 | Continued From page 32<br>evidence of a notice with the required statutory language for the resident to identify a designated representative or documentation that they declined to name a designated representative.<br><br>R2 was admitted and began receiving assisted living with dementia care services on April 22, 2022.<br><br>R2's record included a Residency Agreement, revised January 2021, signed by R2's designated representative on April 22, 2022; however, R2's record lacked an assisted living with dementia care contract with the above required content.<br><br>R3 was admitted on June 14, 2021, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021.<br><br>R3's record included a Residency Agreement, revised January 2021, signed by R3's legal representative on June 25, 2021; however, R3's record lacked an assisted living with dementia care contract with the above required content.<br><br>R4 was admitted on August 3, 2020, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021.<br><br>R4's record included a Residency Agreement, revised January 2021, signed by R4's legal representative on July 29, 2021; however, R4's record lacked an assisted living with dementia care contract with the above required content.<br><br>R5 was admitted March 17, 2017, under the comprehensive home care license and began receiving assisted living with dementia care | 0 950 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 0 950 | Continued From page 33<br>services on August 1, 2021.<br><br>R5's record included a Residency Agreement, revised January 2021, signed by R5's legal representative on July 29, 2021; however, R5's record lacked an assisted living with dementia care contract with the above required content.<br><br>R6 was admitted on June 15, 2021, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021.<br><br>R6's record included a Residency Agreement, revised January 2021, signed by R6's legal representative on August 1, 2021; however, R6's record lacked an assisted living with dementia care contract with the above required content.<br><br>On January 19, 2023, at 12:05 p.m., ED-A stated the licensee's contract had been revised in March 2022 to include the required content; however, she was not aware that she needed to provide the new contract to the existing residents at that time, therefore, R2, R3, R4, R5, and R6 had the previous contract which lacked evidence of a notice with the required statutory language for the resident to identify a designated representative or documentation that they declined to name a designated representative.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 950 | | |
| 0 970 SS=F | 144.50 Subd. 5 Waivers of liability prohibited<br><br>The contract must not include a waiver of facility | 0 970 | | |

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| 0 970 | Continued From page 34<br>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.<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>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).<br><br>The findings include:<br><br>The licensee began providing services under their assisted living facility with dementia care license on August 1, 2021.<br><br>On January 17, 2023, at 12:05 p.m., executive director (ED)-A provided a "survey binder" that included a blank Residency Agreement, revised March 2022, identified as the licensee's assisted living with dementia care contract, and ED-A indicated the documents in the binder were current. | 0 970 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EDGEWOOD BAXTER LLC | 14211 FIREWOOD DRIVE BAXTER, MN 56425 |

| (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 |
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| 0 970 | Continued From page 35<br>R2 was admitted and began receiving assisted living with dementia care services on April 22, 2022.<br><br>R2's record included a Residency Agreement, revised January 2021, signed by R2's designated representative on April 22, 2022.<br><br>R3 was admitted on June 14, 2021, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021.<br><br>R3's record included a Residency Agreement, revised January 2021, signed by R3's legal representative on June 25, 2021.<br><br>R4 was admitted on August 3, 2020, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021.<br><br>R4's record included a Residency Agreement, revised January 2021, signed by R4's legal representative on July 29, 2021.<br><br>R5 was admitted March 17, 2017, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021.<br><br>R5's record included a Residency Agreement, revised January 2021, signed by R5's legal representative on July 29, 2021.<br><br>R6 was admitted on June 15, 2021, under the comprehensive home care license and began receiving assisted living with dementia care services on August 1, 2021. | 0 970 | | |

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| 0 970 | Continued From page 36<br><br>R6's record included a Residency Agreement, revised January 2021, signed by R6's legal representative on August 1, 2021.<br><br>R2, R3, R4, R5, and R6's written contracts included a clause of page 14 of 23, section 27. Personal Property, that included, "Resident agrees that the Community is not responsible for any loss or damage to Resident's personal property due to theft, or damage due to fire, water, tornado or other acts of nature and events beyond the Community's control." Also included on page 14 of 23, section 28. Indemnification, "Resident will indemnify and hold harmless the Community, its employees and agents from and against any and all claims, actions, damages, and liabilities and expenses in connection with loss of life, personal injury or damage to property, arising from or out of the use by Resident of the Apartment or any other part of the Community's property, or caused wholly or in part by an act or omission of Resident or Resident's guests or agents." In addition, a clause on page 15 of 23, section 30. Liability included, "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."<br><br>On January 19, 2023, at 12:05 p.m., ED-A stated the licensee's contract had been revised in March 2022 to include the required content; however, she was not aware that she needed to provide the new contract to the existing residents at that time, therefore, R2, R3, R4, R5, and R6 had the previous contract which included the above language waiving the facility's liability for health, | 0 970 | | |

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| 0 970 | Continued From page 37<br>safety, or personal property of a resident.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 970 | | |
| 01060 SS=F | 144G.52 Subd. 9 Emergency relocation<br><br>(a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care;<br>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and | 01060 | | |

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| 01060 | Continued From page 38 | 01060 | | |

community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and
(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.
(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for three of three residents (R2, R3, R5) hospitalized.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).

The findings include:

R2, R3, and R5's records lacked evidence of a written notice provided to the resident, that contained, at a minimum:
- the reason for the relocation;
- the name and contact information for the location to which the resident had been relocated and any new service provider;
- contact information for the Office of Ombudsman for Long-Term Care (OOLTC);
- if known and applicable, the approximate date

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| 01060 | Continued From page 39<br>or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and<br>- a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal.<br><br>R2<br>R2 was admitted for services on April 22, 2022, with diagnoses including cerebral infarction (stroke), dementia, type 2 diabetes, hypertension (high blood pressure), atrial fibrillation (irregular often fast heartbeat).<br><br>R2's Service Plan (Private) - Addendum to Contract, dated January 17, 2023, indicated R2 received services including assistance with catheter care, medication administration, dressing, hygiene, bowel movement management, behavior management, brace/prosthesis assist, escort, and transfer assist.<br><br>R2's Resident Notes-One Resident, dated January 13, 2023, at 12:31 p.m., identified as the clinical update, 14-day post hospital stay, indicated R2 was hospitalized from December 14, 2022, to December 30, 2022, for a fracture of the right ankle.<br><br>R2's record lacked evidence of R2 being provided with a written notice including the required content for an emergency relocation and lacked evidence of notification to the Office of Ombudsman for Long-Term Care when R2 did not return to the facility within four days, as required. | 01060 | | |

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| 01060 | Continued From page 40<br><br>During an interview on January 19, 2023, at 12:02 p.m., with corporate nurse (CN)-C and clinical nurse supervisor (CNS)-B, CN-C stated she was aware of the notice required, and stated, "We do provide the notice, whenever we send a letter, we send to the Ombudsman too." CNS- B reported that the notice should have been uploaded in R2's documents.<br><br>On January 19, 2023, at 12:40 p.m., executive director (ED)-A stated there was no written notice that she could find.<br><br>R3<br>R3 was admitted for services on June 14, 2021, with diagnoses included Alzheimer's dementia, late onset, with behavioral disturbance.<br><br>R3's Service Plan-Modification dated July 14, 2021, indicated R3 received services including assistance with medication administration, dressing, hygiene, showering, bowel movement tracking, monthly blood pressure, pulse, respirations, and weight monitoring, daily pulse oximeter and temperature monitoring, behavior management, and daily safety checks.<br><br>R3's Resident Notes dated November 10, 2022, at 4:32 p.m., identified as hospital admission, indicated R3 was admitted to the hospital for pneumonia. R3's Resident Notes dated November 14, 2022, at 12:25 p.m., indicated R3 returned to the facility post hospital stay.<br><br>R3's record lacked evidence of R3 being provided with a written notice including the required content for an emergency relocation as required.<br><br>During an interview on January 19, 2023, at 1:07 p.m., CNS-B stated there was no written notice | 01060 | | |

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| 01060 | Continued From page 41<br>that she could find, and verified a relocation notice was not provided to the resident, the residents' legal representative, and designated representative, as required.<br><br>R5<br>R5's diagnoses included coronary artery disease, weakness, respiratory failure, diabetes, and bladder cancer.<br><br>R5's Service Plan (Waiver) - Addendum to Contract, dated November 30, 2022, indicated R5 received services including anti-embolism hose, behavior monitoring, medication administration, blood glucose monitoring, vitals monitoring, nail care, dressing, showers, housekeeping, and laundry.<br><br>R5's Resident Notes - One Resident, noted the following:<br>- On December 8, 2022, at 6:44 a.m., R5 had an unwitnessed fall. There were no injuries;<br>- On December 8, 2022, at 10:47 a.m., the registered nurse (RN) was notified by staff that R5's blood pressure was reading 60/30. RN indicated R5 was very pale, dusky in color, unable to hold her head up, and unable to balance herself on the toilet. R5 complained of right knee pain from a previous fall, but no complaints of other pain was offered. R5 was able to assist while transferring from the toilet to the wheelchair, and then became unresponsive. Sternal rub was performed with no response. Emergency medical services (EMS) were called for immediate transfer to the emergency department. R5 did become responsive after a few minutes and blood pressure reading was 84/62. When EMS arrived, R5 had another unresponsive episode and was transferred to the hospital for evaluation and treatment. | 01060 | | |

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| 01060 | Continued From page 42<br><br>- On December 13, 2022, at 10:32 a.m., the facility was notified R5 was sent to the Intensive Care Unit for respiratory issues and the need for assistance with breathing.<br>- On December 16, 2022, at 1:49 p.m., R5 was transferred for rehabilitation services.<br>- On December 20, 2022, at 9:45 a.m., the rehabilitation facility requested clothing and other items for R5, which the staff dropped off to the facility.<br><br>R5's Resident Notes - One Resident lacked information of R5's return to the facility.<br><br>R5's record lacked evidence of R5 being provided with a written notice with the required content for an emergency relocation, and lacked evidence of notification to the Office of Ombudsman for Long-Term Care when R5 did not return to the facility within four days, as required.<br><br>On January 19, 2023, at 12:05 p.m., CNS-B stated she could not verify the date R5 returned from the hospital; however, stated a relocation notice was not provided to the resident, the residents' legal representative, and designated representative, as required, and stated a notice was not delivered to the Office of Ombudsman for Long-Term Care, as required, when the resident had not returned to the facility within four days. CNS-B stated she was unaware of this requirement, therefore, had not provided the relocation notice for any resident that had been hospitalized.<br><br>The licensee's Emergency Relocation policy, revised September 2022, indicated the facility may remove a resident from the facility in an emergency if necessary due to the resident's urgent medical needs or an imminent risk the | 01060 | | |

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| 01060 | Continued From page 43<br>resident posed to the health or safety of another facility resident or staff member, and in the event of an emergency relocation, would provide a written notice that contained the above required content. The notice would be delivered as soon as practicable to the resident, legal representative, and designated representative, and the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility within four days.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01060 | | |
| 01620 SS=E | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(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.<br>(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.<br>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under | 01620 | | |

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| 01620 | Continued From page 44<br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment based on changes in the needs of the resident for two of three residents (R3, R5).<br><br>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 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).<br><br>The findings include:<br><br>During the entrance conference on January 17, 2023, at 10:52 a.m., clinical nurse supervisor (CNS)-B stated the licensee's practice ws to complete an initial comprehensive assessment prior to the resident moving into the facility, then within 14 days, and then every 90 days or with a change in condition.<br><br>CHANGE IN CONDITION ASSESSMENT<br><br>R3<br>R3 was admitted for services on June 14, 2021, with diagnoses included Alzheimer's dementia, late onset, with behavioral disturbance, | 01620 | | |

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| 01620 | Continued From page 45<br>osteoarthritis, spinal stenosis and hypertension.<br><br>R3's Service Plan-Modification dated July 14, 2021, indicated R3 received services including assistance with medication administration, dressing, hygiene, showering, bowel movement tracking, monthly blood pressure, pulse, respirations, and weight monitoring, daily pulse oximeter and temperature monitoring, behavior management, and daily safety checks.<br><br>R3's Resident Notes dated November 10, 2022, at 4:32 p.m., identified as hospital admission, indicated R3 was admitted to the hospital for pneumonia. R3's Resident Notes dated November 14, 2022, at 12:25 p.m., indicated R3 returned to the facility post hospital stay.<br><br>R3's record lacked evidence of an assessment following a hospital stay.<br><br>During an interview on January 19, 2023, at 1:07 p.m., CNS-B stated a reassessment had not been completed for R3 upon return from the hospital, as is their policy.<br><br>R5<br>R5's diagnoses included coronary artery disease, weakness, respiratory failure, diabetes, and bladder cancer.<br><br>R5's Service Plan (Waiver) - Addendum to Contract, dated November 30, 2022, indicated R5 received services including anti-embolism hose, behavior monitoring, medication administration, blood glucose monitoring, vitals monitoring, nail care, dressing, showers, housekeeping and laundry.<br><br>R5's record contained the most recent | 01620 | | |

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| 01620 | Continued From page 46<br>assessment completed, an Assessment by Date, dated November 30, 2022, identified as the 90 day assessment. R5 was hospitalized on December 8, 2022, then transferred to a rehabilitation facility on December 16, 2022. R5's Resident Notes - One Resident lacked information of R5's return to the facility; however, R5's record lacked an assessment after return to the facility.<br><br>On January 19, 2023, at 12:05 p.m., CNS-B stated a reassessment had not been completed for R5 upon return from the hospital, as is their policy.<br><br>The licensee's Assessments, Reviews & Monitoring policy, undated, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services, as needed based on changes in the needs of the resident, and cannot exceed 90 calendar days from the last date of the assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01640 SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(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 | 01640 | | |

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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 |
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| 01640 | Continued From page 47<br>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.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(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.<br>(e) Staff providing services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure one of five resident's (R2) service plan was developed and implemented.<br><br>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).<br><br>The findings include:<br><br>R2's record lacked evidence that a service plan had been developed prior to January 17, 2023.<br><br>R2 was admitted on April 22, 2022, with | 01640 | | |

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| 01640 | Continued From page 48<br><br>diagnoses including cerebral infarction (stroke), atrial fibrillation (irregular heartbeat), acute respiratory failure, type 2 diabetes, hypertension (high blood pressure), and dementia.<br><br>R2's service plan dated and created January 17, 2023, indicated R2 received services including medication administration, morning and evening dressing and hygiene, catheter care, brace/prosthesis, behavior management, bowel tracking, transfer assist, housekeeping, and laundry.<br><br>On January 17, 2023, at 1:52 p.m. R2's service plan created January 17, 2023, unsigned was provided by clinical nurse supervisor (CNS)-B.<br><br>On January 19, 2023, at 8:32 a.m., the evaluator observed unlicensed personnel (ULP)-E administer R2's scheduled medication.<br><br>On January 19, 2023, at 12:43 p.m., CNS-B verified R2 was receiving services under the facility's license; however, did not have a service plan developed and implemented as required.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01640 | | |
| 01750 SS=H | 144G.71 Subd. 7 Delegation of medication administration<br><br>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:<br>(1) instructed the unlicensed personnel in the proper methods to administer the medications, | 01750 | | |

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| 01750 | Continued From page 49<br>and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and<br>(3) communicated with the unlicensed personnel about the individual needs of the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure prior to delegating the nursing task of medication administration, the unlicensed personnel (ULP) demonstrated competency to a registered nurse (RN) for administering medications for one of two ULP (ULP-E).<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a 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).<br><br>This resulted in an immediate order on January 19, 2023, at approximately 3:30 p.m.<br><br>The findings include:<br><br>ULP-E was hired on October 30, 2018, to provide direct care services to residents of the assisted living with dementia care facility.<br><br>On January 18, 2023, at 7:55 a.m., the evaluator observed ULP-E prepare R7's morning | 01750 | On January 19, 2023, the immediacy of correction order 1750 was removed however, non-compliance remained at a level 3, scope of pattern violation. | |

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| 01750 | Continued From page 50 | 01750 | | |

medications and administer to R7 at the breakfast table. Medications prepared by ULP-E included:
-clopidogrel 75 milligrams (mg) one tablet by mouth every day;
-levothyroxine 50 micrograms (mcg) one tablet by mouth every day;
-Allergy Relief one tablet by mouth every day; and
-pantoprazole 20 mg by mouth every day.

On January 18, 2023, at 10:32 a.m., the evaluator observed ULP-E prepare and administer R8's lubricating eye drops into R8's eyes.

ULP-E's record lacked evidence the RN instructed the ULP in the proper methods to administer the medications, and ensured the ULP demonstrated the ability to competently follow the procedures.

On January 19, 2023, at 1:37 p.m., clinical nurse supervisor (CNS)-B stated she was unable to find documentation that ULP-E completed medication training and had demonstrated competency to a RN for administration of medications.

On January 19, 2023, at 2:00 p.m., ULP-E stated she received medication training and competency testing when she was previously employed at a different facility under the same ownership as the licensee. ULP-E stated she was not required to repeat the training and testing when she started working for the licensee in 2018.

On January 19, 2023, at 3:15 p.m., CNS-B stated ULP-E was responsible for passing medications to the residents in the facility's Memory Care, which currently had 13 residents.

The licensee's Delegation Of Assisted Living Services policy, undated, indicated a RN may

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| 01750 | Continued From page 51<br>delegate tasks only to staff who are competent and possess the knowledge and skills consistent with the complexity of the tasks and according to the appropriate Minnesota Practice Act. The policy also indicated, when medication management is delegated to a ULP, the RN will:<br>-instruct the ULP in the proper methods to administer the medications; and<br>-verify the ULP has demonstrated the ability to competently follow the procedures;<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE | 01750 | | |
| 01910 SS=D | 144G.71 Subd. 22 Disposition of medications<br><br>(a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.<br>(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.<br>(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. | 01910 | | |

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| 01910 | Continued From page 52<br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R1) upon discharge, with records reviewed.<br><br>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).<br><br>The findings include:<br><br>R1's record lacked documentation of medication disposition upon R1's discharge from the facility.<br><br>R1 was discharged to a different facility on October 13, 2022, after receiving services for diagnoses including Wernicke's Encephalopathy (a degenerative brain disorder), frailty, chronic obstructive pulmonary disease, and major depressive disorder.<br><br>R1's Discharge - Transfer Summary, printed October 17, 2022, indicated R1 received services including supervisory care with some redirection required, needed some supervision to bathe/shower including stand by assistance for safety, needed help with choosing clothing or laying out clothes, and medication management and administration. The discharge summary listed R1's medications including the medication's name, strength, to whom the medications were | 01910 | | |

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| 01910 | Continued From page 53<br>given, and date of disposition, and indicated, "All medication was sent with Guardian at time of discharge."<br><br>R1's record lacked documentation of the disposition of the medications including the quantity of each medication, the prescription number as applicable, and names of staff and other individuals involved in the disposition, as required.<br><br>On January 17, 2023, at 3:37 p.m., clinical nurse supervisor (CNS)-B stated R1's guardian took the medications; however, a disposition with the required information could not be found.<br><br>The licensee's Medication Disposal policy, undated, indicated any current medications being managed by the licensee must be provided to the resident when the resident's service plan ended, or medication management services were no longer part of the service plan, and included, upon disposition, the licensee must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01910 | | |
| 01940 SS=D | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>For each resident receiving management of | 01940 | | |

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| 01940 | Continued From page 54<br>ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of three residents (R2).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 01940 | | |

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| 01940 | Continued From page 55 | 01940 | | |

safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

During the entrance conference on January 17, 2023, at 10:51 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided treatment and therapy services to residents.

R2 was admitted on April 22, 2022, with diagnoses including cerebral infarction (stroke), atrial fibrillation (irregular heartbeat), acute respiratory failure, type 2 diabetes, hypertension (high blood pressure), and dementia.

R2's service plan dated January 17, 2023, indicated R2 received services including medication administration, morning and evening dressing and hygiene, catheter care, brace/prosthesis, behavior management, bowel tracking, transfer assist, housekeeping, and laundry.

R2's Individualized Treatment and Therapy Plan reviewed on January 17, 2023, at 1:52 p.m., was blank.

R2's Plan Service Detail, revised on January 17, 2023, indicated R2 required assistance with a brace in the morning, evening and overnight, directing to apply brace while transferring and remove while resident was in bed.

R2's Resident Notes dated January 17, 2023, at

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| 01940 | Continued From page 56<br><br>10:19 a.m., indicated R2's orthopedic doctor gave the following verbal order for R2's brace/boot: "Ok to leave walking boot off while in bed. If resident is to transfer or be up on his wheelchair, brace will be applied."<br><br>R2's record lacked an individualized treatment and therapy plan to include:<br>-identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>-procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>-any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions.<br><br>On January 19, 2023, at 12:47 p.m., CNS-B stated she was able to see the Individualized Treatment and Therapy Plan in her electronic access and stated there was a glitch in the electronic system that evaluators could access; however, stated R2's record lacked the above information regarding the treatment plan for R2's boot (brace).<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01940 | | |
| 02040 SS=F | 144G.81 Subdivision 1 Fire protection and physical environment<br><br>An assisted living facility with dementia care that | 02040 | | |

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| 02040 | Continued From page 57<br>has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements:<br>(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<br>(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.<br><br>This MN Requirement is not met as evidenced by:<br>Based on available record review and interview, the licensee did not provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors.<br><br>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).<br><br>Findings include:<br><br>A record review and interview were conducted January 17, 2023, at approximately 11:45 a.m. with director of maintenance (DM)-D on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability | 02040 | | |

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| 02040 | Continued From page 58<br>assessment with mitigation factors on and around the interior and exterior of this specific property.<br><br>This deficiency was verified by DM-D during the interview at approximately 11:45 a.m.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 02040 | | |
| 02110 SS=F | 144G.82 Subd. 3 Policies<br><br>(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:<br>(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;<br>(2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;<br>(3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes;<br>(4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications;<br>(5) staff training specific to dementia care;<br>(6) description of life enrichment programs and how activities are implemented;<br>(7) description of family support programs and efforts to keep the family engaged;<br>(8) limiting the use of public address and intercom systems for emergencies and | 02110 | | |

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| 02110 | Continued From page 59<br>evacuation drills only;<br>(9) transportation coordination and assistance to and from outside medical appointments; and<br>(10) safekeeping of residents' possessions.<br>(b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were provided to each resident and/or the residents legal/designated representative at the time of move-in. This had the potential to affect all residents with dementia care.<br><br>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).<br><br>The findings include:<br><br>The licensee lacked evidence the required policies and procedures related to dementia care were provided to each resident and/or the resident's legal and designated representative.<br><br>The licensee held an assisted living with dementia care license through August 31, 2023, and was licensed for a bed capacity of 85 | 02110 | | |

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| EDGEWOOD BAXTER LLC | 14211 FIREWOOD DRIVE BAXTER, MN 56425 |

| (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 |
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| 02110 | Continued From page 60<br>residents.<br><br>On January 19, 2023, at 12:05 p.m., corporate nurse (CN)-C provided the required policies and procedures to the evaluators; however, indicated no evidence was found to verify the inclusive list of dementia care policies and procedures had been provided to each resident and/or representative.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 02110 | | |
| 02170 SS=F | 144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA<br><br>(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:<br>(1) past and current interests;<br>(2) current abilities and skills;<br>(3) emotional and social needs and patterns;<br>(4) physical abilities and limitations;<br>(5) adaptations necessary for the resident to participate; and<br>(6) identification of activities for behavioral interventions.<br>(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.<br>(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not | 02170 | | |

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| 02170 | Continued From page 61<br><br>limited to:<br>(1) occupation or chore related tasks;<br>(2) scheduled and planned events such as entertainment or outings;<br>(3) spontaneous activities for enjoyment or those that may help defuse a behavior;<br>(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;<br>(5) spiritual, creative, and intellectual activities;<br>(6) sensory stimulation activities;<br>(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and<br>(8) outdoor activities.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop an individualized activity plan based on the activity evaluation, for five of five residents (R2, R3, R4, R5, R6).<br><br>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).<br><br>The findings include:<br><br>The licensee had an assisted living with dementia care (ALFDC) license effective August 1, 2022.<br><br>R2<br>R2's diagnoses included cerebral infarction (stroke), atrial fibrillation (irregular heartbeat), acute respiratory failure, type 2 diabetes, | 02170 | | |

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| 02170 | Continued From page 62<br>hypertension (high blood pressure), and dementia.<br><br>R2's service plan dated January 17, 2023, indicated R2 received services which included medication administration, morning and evening dressing and hygiene, catheter care, brace/prosthesis, behavior management, bowel tracking, transfer assist, housekeeping, and laundry.<br><br>R2's record included an Assessment by Date, dated December 30, 2022, identified as the clinical updated assessment after return from hospital stay, included an evaluation for activities; however, lacked an individualized activity plan based on the activity evaluation that reflected R2's activity preferences and needs, as required.<br><br>R3<br>R3's diagnoses included Alzheimer's Disease with behavioral disturbance, osteoarthritis, lumbar spine stenosis (narrowing of spinal column), and hypertension.<br><br>R3's Service Plan - Modification, dated July 14, 2021, indicated R3 received services including dressing, hygiene, behavior monitoring, medication administration, vital monitoring, safety checks, assist with showering, toileting, housekeeping, and laundry.<br><br>R3's record included an Assessment by Date, dated December 7, 2022, identified as the 90-day assessment, which included an evaluation for activities; however, lacked an individualized activity plan based on the activity evaluation that reflected R3's activity preferences and needs, as required. | 02170 | | |

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| 02170 | Continued From page 63<br>R4<br>R4's diagnoses included bipolar disorder (mental condition alternating periods of elation and depression).<br><br>R4's Service Plan, dated July 22, 2021, indicated R4 received services including dressing, hygiene, ambulation, exercise, assistance with meals, behavior monitoring, escort, vital monitoring, incontinence care, oxygen management, medication administration, safety checks, transfer assist, housekeeping, and laundry.<br><br>R4's record included an Assessment by Date, dated November 25, 2022, identified as the 90-day assessment, which included an evaluation for activities; however, lacked an individualized activity plan based on the activity evaluation that reflected R4's activity preferences and needs, as required.<br><br>R5<br>R5's diagnoses included coronary artery disease, weakness, respiratory failure, diabetes, and bladder cancer.<br><br>R5's Service Plan (Waiver) - Addendum to Contract, dated November 30, 2022, indicated R5 received services including anti-embolism hose, behavior monitoring, medication administration, blood glucose monitoring, vitals monitoring, nail care, dressing, showers, housekeeping, and laundry.<br><br>R5's record included an Assessment by Date, dated November 30, 2022, identified as the 90-day assessment, which included an evaluation for activities; however, lacked an individualized activity plan based on the activity evaluation that reflected R5's activity preferences and needs, as | 02170 | | |

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| 02170 | Continued From page 64<br>required.<br><br>R6<br>R6's diagnoses included cerebral vascular accident (stroke), spinal stenosis (spaces in the spine narrow causing pressure on the spinal cord and nerve roots), diabetes, osteoarthritis of knee, low back pain, and Parkinson's Disease.<br><br>R6's Service Plan (Private) - Addendum to Contract, dated August 27, 2021, indicated R6 received services including dressing, ambulation/exercise, behavior management, medication set up, monthly vital monitoring, positioning, nail care, shower, and safety checks.<br><br>R6's record included an Assessment by Date, dated December 20, 2022, identified as the 90-day assessment, which included an evaluation for activities; however, lacked an individualized activity plan based on the activity evaluation that reflected R6's activity preferences and needs, as required.<br><br>On January 19, 2023, at 11:45 a.m., life enrichment director (LED)-I stated she was not currently involved in the admission process and knew she was supposed to be completing an individualized activity plan based on the activity evaluation; however, stated she had not completed a written activity plan for any of the residents. LED-I stated she was recently made aware that she would be involved in the admission process in the future.<br><br>The licensee's Enrichment Programs, Activities & Outdoor Space policy, dated January 2022, indicated a Life History and Memorable Moments form would be completed for each resident upon admission, and Life Enrichment staff would visit | 02170 | | |

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| 02170 | Continued From page 65<br>with the resident and/or family to complete the form. Also included, each resident must be evaluated for activities according to the licensing rules of the community, and an individualized activity plan must be developed for each resident based on their activity evaluation, that must reflect the resident's activity preferences and needs.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 02170 | | |
| 02240 SS=D | 144G.90 Subdivision 1 Assisted living bill of rights; notification<br><br>(a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand.<br>(b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse:<br>"If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities."<br>(c) The statement must include contact | 02240 | | |

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| 02240 | Continued From page 66<br>information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint.<br>(d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to the resident and a written acknowledgement received for one of five residents (R2) with records reviewed.<br><br>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). | 02240 | | |

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| 02240 | Continued From page 67<br><br>The findings include:<br><br>The license had a current assisted living with dementia care license.<br><br>R2<br>R2's diagnoses included cerebral infarction (stroke), atrial fibrillation (irregular heartbeat), acute respiratory failure, type 2 diabetes, hypertension (high blood pressure), and dementia.<br><br>R2's service plan, dated January 17, 2023, indicated R2 received services which included medication administration, morning and evening dressing and hygiene, catheter care, brace/prosthesis, behavior management, bowel tracking, transfer assist, housekeeping, and laundry.<br><br>On January 19, 2023, at 8:32 a.m., the evaluator observed unlicensed personnel (ULP)-E administer R2's scheduled morning medication.<br><br>R2's record lacked a copy of a written acknowledgement received of the current Minnesota Bill of Rights for Assisted Living Residents.<br><br>On January 19, 2023, at approximately 12:39 p.m., executive director (ED)-A verified R2 had not received the current Minnesota Bill of Rights for Assisted Living Residents, as required.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 02240 | | |

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| 02310 | Continued From page 68 | 02310 | | |
| 02310 SS=H | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for four of five residents (R2, R3, R5, R6) with hospital beds with bedrails.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a 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).<br><br>This resulted in an immediate correction order on January 18, 2023, at approximately 5:10 p.m.<br><br>The findings include:<br><br>R2<br>On January 18, 2023, at 7:51 a.m., the evaluator observed R2's bilateral bedrails, firmly affixed to the hospital bed frame, both were in the raised position. | 02310 | On January 19, 2023, the immediacy of correction order 2310 was removed, as verified by survey supervisor and survyors on-site, however, non-compliance remained at a level 3, scope of pattern violation. | |

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| 02310 | Continued From page 69<br><br>On January 18, 2023, at 7:59 a.m., unlicensed personnel (ULP)-E stated R2 used the bedrails to hold on to when transferring, when sitting up in bed, and while eating.<br><br>On January 18, 2023, at 8:32 a.m., the evaluator observed R2 lying in bed. R2 used the right bedrail to sit up in bed to take his medications from ULP-E.<br><br>R2 was admitted April 22, 2022, with diagnoses including cerebral infarction (stroke), dementia, type 2 diabetes, and hypertension (high blood pressure).<br><br>R2's record lacked a service plan.<br><br>R2's Service Recap Summary-Month, dated January 2023, indicated R2 received services including positioning and transfer assist, safety checks, as needed medication follow-up, anticoagulation protocol, falls protocol, medication assistance/administration, monitor blood glucose Tuesday and Friday, dressing, hygiene, behavior management, stool record, brace, catheter care, laundry, and housekeeping.<br><br>R2's Assessment As Of Date, dated December 30, 2022, identified as Return from Hospital Stay, indicated under Safety, R2 had no assistive devices, had a standard bed frame, and no bedrails in use.<br><br>R2's Assessment As Of Date, dated January 13, 2023, identified as the 14-day Post Hospital Stay, indicated under Safety, R2 had no assistive devices on the bed and had a standard bed frame; however, noted "Quarter rails at head of bed." There was no further information regarding | 02310 | | |

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| 02310 | Continued From page 70<br>the bed rails.<br><br>R2's record lacked evidence of education of the risks and benefits associated with the use of bedrails.<br><br>R2's record lacked a comprehensive assessment to include evidence of physical inspection of the bedrail and mattress for areas of entrapment and stability of the device, which included actual measurements of the entrapment zones and documentation that the resident and the resident's representative had been provided information on the risks and benefits of bedrails.<br><br>R3<br>On January 18, 2023, at 7:55 a.m., the evaluator observed R3's hospital bed, with bilateral bedrails. The right bedrail was in the raised position and the left bedrail was in the lowered position.<br><br>On January 18, 2023, at 9:20 a.m., ULP-E stated R3 had been experiencing increased weakness and was using the right bedrail to assist with positioning from lying to sitting.<br><br>On January 18, 2023, at 2:15 p.m., R3 stated the left bedrail was always "down." When the evaluator asked when he used the bedrails, R3 stated, "I never use it. I don't know why it's here."<br><br>R3 was admitted on June 14, 2021, with diagnoses including Alzheimer's Disease with behavioral disturbance, osteoarthritis, lumbar spine stenosis (narrowing of spinal column), and hypertension.<br><br>R3's Service Plan Modification, dated July 14, 2021, indicated R3 received services including | 02310 | | |

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| 02310 | Continued From page 71<br>dressing, grooming, behavior monitoring, medication administration, safety checks, stool record, housekeeping, and laundry.<br><br>R3's Assessment As Of Date, dated December 7, 2022, identified as 90 Day Clinical Update, indicated under Safety, R3 had a hospital bed with no rails in use. There was no further information regarding the bedrails.<br><br>R3's record lacked evidence of education of the risks and benefits associated with the use of bedrails.<br><br>R3's record lacked a comprehensive assessment to include evidence of physical inspection of the bedrail and mattress for areas of entrapment and stability of the device, which included actual measurements of the entrapment zones and documentation that the resident and the resident's representative had been provided information on the risks and benefits of bedrails.<br><br>R5<br>On January 18, 2023, at 10:40 a.m., the evaluator observed R5's bilateral bedrails, firmly affixed to the hospital bed frame, both were in the raised position. R5 was lying in the bed and stated she used the bedrails to get up and to turn from side to side.<br><br>R5 was admitted on March 17, 2017, with diagnoses including coronary artery disease, pneumonia, congestive heart failure, osteoarthritis of knee, history of falls, shortness of breath, weakness, and obesity.<br><br>R5's Service Plan (Waiver)-Addendum to Contract, dated November 30, 2022, indicated R5 received services including compression | 02310 | | |

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| 02310 | Continued From page 72 | 02310 | | |

stockings, behavior monitoring, medication administration, blood glucose monitoring, monthly vital monitoring, daily weight monitoring, diabetes protocol, congestive heart failure protocol, housekeeping, and laundry.

R5's Bed Rail Waiver, dated October 27, 2022, included risks of bedrails and R5 signed indicating she was given a copy of the FDA (Food and Drug Administration) informational packet about bedrails, and she chose to have a bedrail, having discussed the risks associated with bedrails and the facility's policy on bedrail usage. The assessment indicated R5 was alert and oriented, used the bedrails to assist with bed mobility and repositioning when in bed.
Also included, RN (registered nurse) Assessment indicated, "Zones 1-4 are compliant with FDA regulations," however, the assessment lacked documentation of measurements of the entrapment zones.

R5's Assessment As Of Date, dated November 30, 2022, identified as the 90 day assessment, indicated under Safety, R5 had no assistive devices needed for bed and the Bed Safety Zones was "not applicable." There was no further information regarding the bedrails.

R5's record lacked a comprehensive assessment to include evidence of physical inspection of the bedrail and mattress for areas of entrapment and stability of the device, which included actual measurements of the entrapment zones.

R6
On January 18, 2023, at 8:17 a.m., R6 was sitting in his apartment, watching television. The evaluator observed R6's bilateral bedrails affixed to the hospital bed frame. Both bedrails were in

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| EDGEWOOD BAXTER LLC | 14211 FIREWOOD DRIVE BAXTER, MN 56425 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 73 | 02310 | | |

the raised position, with the right bedrail tight to the bed; however, the left bedrail was loose and could easily be moved from side to side and front to back. R6 stated he used both bedrails to get in and out of bed and to turn from side to side while in bed.

R6 was admitted on June 15, 2021, with diagnoses including cerebrovascular accident (stroke), lumbar spinal stenosis, diabetes, bladder cancer, osteoarthritis of knee, low back pain, lumbar laminectomy (opening in the bone to relieve pressure), and Parkinson's Disease with resting tremor.

R6's Service Plan (Private)-Addendum to Contract, dated August 27, 2021, indicated R6 received services including dressing, ambulation, behavior management, medication set up complex, monthly vital monitoring, positioning, safety check, shower, and transfer assist.

R6's Bed Rail Waiver, dated October 27, 2022, included risks of bedrails and R6 signed indicating he was given a copy of the FDA informational packet about bedrails, and he chose to have a bedrail, having discussed the risks associated with bedrails and the facility's policy on bedrail usage. Also included, RN Assessment indicated, "Zones 1-4 are compliant with FDA regulations," however, the assessment lacked documentation of measurements of the entrapment zones. Further, the assessment indicated R6 was alert and oriented, used the bedrails to remain independent with bed mobility and repositioning when in bed.

R6's Assessment by Date, dated December 20, 2022, identified as Clinical Update, indicated under Safety, R6 had an electric bed with quarter

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30293 | A. BUILDING: _____ B. WING _____ | 01/20/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| EDGEWOOD BAXTER LLC | 14211 FIREWOOD DRIVE BAXTER, MN 56425 |

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|---|---|---|---|---|
| 02310 | Continued From page 74<br><br>rails at the head of the bed, and noted resident required use of the left bedrail to assist with repositioning in bed and transfers out of bed, and, indicated the right bedrail is not used and was always in the down position. The assessment included Bed Safety Zones and indicated Zone 1 (area within the rail), Zone 2 (area under the rail), and Zone 3 (area between the rail and the the mattress) were less than 4-3/4 inches. The assessment directed to note measurements in note field; however, no measurements were documented. Zone 4 (area under the rail) noted, "Standard hospital bed 1/4 rail." Zone 5 (space between the split bedrails) noted as not applicable, and Zone 6 (gap between the end of the bedrail and the side edge of the headboard or footboard) noted did not present a risk of entrapment of the head, neck, or chest. Zone 7 (space between the inside surface of the headboard/footboard and the end of the mattress) noted as not applicable.<br><br>R6's record lacked a comprehensive assessment to include evidence of physical inspection of the bedrail and mattress for areas of entrapment and stability of the device, which included actual measurements of the entrapment zones.<br><br>On January 18, 2023, at 11:20 a.m., clinical nurse supervisor (CNS)-B stated the process when a resident had a bedrail, included discussing risks and benefits of using the bedrails and having the resident or their representative sign to indicate they were educated, and an assessment was completed with measurements; however, indicated she did not document the measurements specifically and stated, "On our assessment, it says that the hospital beds are FDA approved. I didn't understand I guess." CNS-B also stated because all hospital beds | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30293 | A. BUILDING: _____ B. WING _____ | 01/20/2023 |

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| EDGEWOOD BAXTER LLC | 14211 FIREWOOD DRIVE BAXTER, MN 56425 |

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|---|---|---|---|---|
| 02310 | Continued From page 75 | 02310 | | |

were "standard," and all the same, she didn't realize she needed to document the measurements.

The licensee's Side Rails-MN, dated October 2022, indicated when bedrails were in use, an RN must conduct an assessment to identify the intended purpose of the bedrail and the risks regarding the use of the bedrail. Staff would determine if the bedrail was considered safe, ensuring it was used consistent with manufacturer's directions, installed securely and maintained in good operating condition, and were consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment, meaning zones 1, 2, and 3 must not exceed 4.75 inches. The policy also noted the resident and when appropriate, the resident's representative, would be informed of the risks and benefits regarding the use of the bedrails and documented in the resident's record. Further, the policy indicated local known hospice providers and known medical equipment suppliers would be informed that residents of the facility would only be permitted to use bedrails that comply with the 2006 FDA dimensional guidance to reduce entrapments.

The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs), indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30293 | A. BUILDING: _____ B. WING _____ | 01/20/2023 |

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| EDGEWOOD BAXTER LLC | 14211 FIREWOOD DRIVE BAXTER, MN 56425 |

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| 02310 | Continued From page 76<br>without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint. Additionally, the licensee must ensure the bed rail measurements are documented and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations." Also included, "Documentation about a resident's bed rails includes, but is not limited to:<br>-Purpose and intention of the bed rail;<br>-Measurements<br>-The resident's bed rail use/need assessment;<br>-Risk vs. benefits discussion (individualized to each resident's risks);<br>-The resident's preferences;<br>-Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and<br>-Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements."<br><br>The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE | 02310 | | |

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

Type: Full
Date: *01/17/23*
Time: 10:45:00
Report: 6808231018

# Food and Beverage Establishment Inspection Report



**Location:**
Edgewood Baxter LLC
14211 Firewood Drive
Baxter, MN56425
Crow Wing County, 18

**Establishment Info:**
ID #: 0017343
Risk: Medium
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**
Edgewood Baxter, LLC

Phone #: 2188284770
ID #: 46463

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 previously issued on 04/21/21 have NOT been corrected.

**3-500B Microbial Control: hot and cold holding**
***3-501.16A2*** ***** Priority 1 *****
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
FOODS IN THE UNDERCOUNTER COOLER WERE 43-45 DEGREES. UNIT WAS ADJUSTED. 1/17/23 FOODS WERE 51 DEGREES IN THE UNDERCOUNTER COOLER.
*Issued on: 04/21/21* *Comply By: 04/21/21*

The following orders were issued during this inspection.

**2-200 Employee Health**
***2-201.11C*** ***** Priority 1 *****
MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
AN EMPLOYEE ILLNESS LOG MUST BE KEPT AND ILLNESSES DOCUMENTED ON IT. ONE IS ATTACHED WITH THIS REPORT.
*Comply By: 01/18/23*

**3-700 Contaminated Food: discarded**
***3-701.11A*** ***** Priority 1 *****
MN Rule 4626.0445A Discard or recondition food that is unsafe, adulterated or not honestly presented.
FOODS IN THE UNDERCOUNTER COOLER THAT WERE 51 DEGREES WERE DISCARDED INCLUDING: PRE-MADE CHEF SALADS, CUT TOMATOES AND CUT GREENS
*Corrected on Site*

**2-100 Supervision**

***2-102.12DMN***

MN Rule 4626.0033D Post the certified food protection manager certificate.

POST MICHELE'S CERTIFICATE.

*Comply By: 01/18/23*

**4-500 Equipment Maintenance and Operation**

***4-501.11AB***

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

ADJUST OR REPAIR THE UNDERCOUNTER COOLER. IF IT CAN'T MAINTAIN FOODS AT 41DEGREES OR BELOW, IT MUST BE REPLACED.

*Comply By: 01/17/23*

**Surface and Equipment Sanitizers**

Acid: = 7.0 at Degrees Fahrenheit
Location: SMART POWER SANITIZER IN WIPING CLOTH SOL.
Violation Issued: No

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: DISHWASHER RINSE
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cold Holding
Temperature: 51 Degrees Fahrenheit - Location: TOMATOES, SALAD, CANTELOPE IN UNDERCOUNTER UNIT
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: TOMATOES IN 2-DOOR
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: HAM IN 1-DOOR
Violation Issued: No

Process/Item: Steam Table
Temperature: 194 Degrees Fahrenheit - Location: PORK CHOPS
Violation Issued: No

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

# 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 6808231018 of 01/17/23.

Certified Food Protection Manager: Michele Heilman

Certification Number: _____ Expires: 08/26/23

Signed: _____
Establishment Representative

Signed: Lee Ann Austin

Lee Ann Austin
Public Health Sanitarian
St. Cloud
320-223-7341
leeann.austin@state.mn.us