Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL302932004M
Compliance #: HL302933342C

Date Concluded: June 27, 2025

Name, Address, and County of Licensee Investigated:
Edgewood Baxter
14211 Firewood Drive
Baxter, MN 56425
Crow Wing County

Facility Type: Assisted Living Facility with Dementia Care (ALFDC)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Substantiated, facility responsibility

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when it failed to implement interventions to ensure the resident's safety. The resident had known behaviors towards other residents and staff failed to put interventions in place to ensure the resident's safety.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was substantiated. The facility was responsible for the maltreatment. Facility staff failed to identify, assess, and implement interventions to address the resident's behavior despite knowledge of multiple incidents and altercations involving other residents and contact with police.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator contacted law enforcement. The investigation included review of the resident records, facility incident reports, personnel files, staff schedules, law enforcement reports, body camera footage, and related facility policy and

procedures. Also, the investigator observed the resident’s interactions with other residents at the facility.

The resident resided in an assisted living facility. The resident’s diagnoses included dementia, anxiety, and hearing loss. The resident’s service plan included assistance with behavior management for wandering and physical aggression. The resident’s assessment indicated the resident had behaviors, including a history of wandering into other resident's apartments, touching other residents, and kicking and poking at other residents. The assessment indicated the resident was able to communicate but may not be consistent due to dementia. Staff were to anticipate needs and advocate for the resident. The resident was noted to have moderately impaired cognition with memory problems. Facility documentation indicated the resident’s family requested bullying by other residents to be added to his assessment; however, the resident’s assessment lacked any documentation on bullying or concerns with the resident being bullied or him bullying other residents.

Police reports reviewed identified police were contacted six times over a three-month period for the following incidents:

- the facility called police to report the resident (R1) was being disruptive, harassing staff, and attempting to enter other resident's rooms. Police advised R1 return to his room. Facility documentation lacked any documentation of a police response or that family had been notified.

- the facility called police for R1 playing loud music. Facility documentation indicated the executive director requested staff call police for assistance with the R1's behaviors. Facility documentation lacked evidence family was notified.

- staff called police to report R1 was sexually harassing residents and refusing to go to his room. Police escorted R1 back to his room. Facility documentation lacked any documentation of a police response or that family had been notified.

- staff called police to report R1 was making inappropriate sexual comments and grabbed the director by the arm. Facility documentation lacked any documentation of a police response or that family had been notified.

-a visitor called police around 5:30 p.m. to report R1 was harassing other residents. Facility documentation indicated the resident's power of attorney was called at 6:00p.m.

-the facility called police after R1 had a physical altercation with another resident. Facility documentation indicated the power of attorney was notified at 6:29 p.m., and police were called at 6:33 p.m

Despite ongoing behaviors and police contact there was no additional assessment or interventions implemented to address the resident’s behavior. Five months of facility

documentation was reviewed, and records indicated there were frequent and ongoing interactions and altercations between the resident and other residents at the facility.

There were several documented incidents of resident to resident altercations including when another resident threatened to hit the resident with a shoe, the resident was grabbed by another resident, the resident was threatened with a knife by another resident, the resident had water dumped on him by another resident, and other residents made comments to him including to go away, “I’m going to slap you so hard you won’t wake up,” that he belongs in a looney bin, and that no one likes him. Facility documentation indicated the resident’s family filed a grievance regarding the resident being bullied, however the grievance was not responded to as the facility requested the family provide specifics on bullying allegations. There was no documentation of investigation of many of the documented allegations and staff were not interviewed to determine if the resident was being bullied by other residents as alleged by the resident’s family. The resident’s family brought up in a care conference that they felt the resident was being bulled and wanted a police report made. The facility filed a vulnerable adult report but failed to take further action.

The resident’s assessment was not updated to include the family’s concerns on the resident being bullied. The resident’s individual abuse prevention plan lacked any documentation on the resident being bullied or the ongoing resident to resident altercations or continued contact with police. Facility records indicated nursing would often document the resident’s behaviors and note that interventions were not successful, however they failed to identify new interventions or determine why interventions were not successful. The resident had many behaviors that the facility failed to assess including playing loud music, following staff into resident rooms, interrupting activities, or eating food off other resident’s plates.Documentation indicated the resident’s family requested adding certain interventions they felt might be successful, however the family’s suggestions were never added to the assessment or care plan.

During staff interviews, multiple staff members stated they had observed the resident get bullied and that he sometimes initiated the bullying. Multiple staff members stated they had observed a group of residents start saying rude things to the resident without the resident doing anything to provoke them first. Multiple staff members stated they had limited interventions for the resident’s behaviors and many times, interventions were not successful, which nursing was aware of.

Facility management stated it was an unfortunate situation between the resident and some other residents and that there was some bullying in the building. Management stated they didn’t think anyone understood how much work the facility had put in to help the situation for the resident and all the other residents to make everyone feel safe and were trying to intervene as much as they could. Facility management felt they had implemented many interventions to manage the resident’s behaviors.

A nurse manager stated she was not aware of any bullying of the resident.

The visitor who contacted police over the resident’s behavior was interviewed and stated that she only called the police because the resident kept bothering another resident and staff were not able to assist her with removing him. The visitor stated that she asked staff what she was supposed to do about R1's behaviors and staff said she needed to call the police so she did. The visitor stated that she didn't know R1 well at that point or else she would have tried redirecting him and after observing how police interacted with him, she regretted that she called police for help.

During an interview, the resident’s power of attorney (POA) stated the facility failed to consider and implement intervention options suggested and provided to them by the resident’s family members. The POA also indicated they had not been told of many of the police calls made and only found out after they spoke with a responding officer after the last phone call when the officer made a comment that they had been there a few times before due to the resident’s behaviors. The POA stated when they requested police records from the police department they were "floored" when they saw how many times officers had been called to intervene and they were never notified and would have expected to be called before police were called as it was in his plan of care. The POA stated they had suggested many interventions to help with the resident’s behaviors but the facility was resistant to implementing them or found reasons why they couldn't try the interventions.

During an interview, law enforcement stated they didn’t believe the facility had disclosed to them that the resident had any cognitive impairments at the time law enforcement was initially called.

The resident was interviewed and stated "nobody likes me" and that he "just tries to be friendly and they all just hate me” …"people hate me so they call the police."

In conclusion, the Minnesota Department of Health determined neglect was substantiated.

Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.
“Substantiated” means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
No action taken.

Action taken by the Minnesota Department of Health:
The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4200 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Crow Wing County Attorney
Baxter City Attorney
Baxter Police Department
Minnesota Board of Nursing
Minnesota Board of Executives for Long Term Services and Supports

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 _____	C 05/06/2025

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
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL302932004M/ #HL302933342C On May 6, 2025, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 52 residents receiving services under the provider's Assisted Living with Dementia Care license. The following correction orders are issued for #HL302932004M/ #HL302933342C, tag identification 0450, 0630, 2350, 2360, 2480.	0 000		
0 450 SS=F	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to	0 450		

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 _____	C 05/06/2025

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
0 450	Continued From page 1 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to provide services in a person-centered manner for one of one residents reviewed (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: DEMENTIA DIAGNOSIS The licensee failed to ensure staff were aware of a resident's diagnosis of dementia and that the resident had cognitive impairment as a result of that diagnosis. R1's diagnoses included dementia, anxiety, and hearing loss. R1's service plan dated March 28, 2025, indicated the resident received services including	0 450		

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 _____	C 05/06/2025

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
0 450	Continued From page 2 behavior management for wandering and physical aggression, as well as "other mental health need." R1's assessment dated May 1, 2025, indicated the resident had behaviors, including a history of wandering into other resident's apartments, touching other residents, and kicking and poking at other residents. The resident was able to communicate but may not be consistent due to dementia. Staff were to anticipate needs and advocate for the resident. R1 was noted to have moderately impaired cognition with memory problems. R1 was not able to recognize that he was making others uncomfortable due to his dementia. Interventions for the R1's behaviors included approaching calmly, redirecting, remove resident from situation, offer to go for a walk, offer a snack, validate feelings, engage in conversation about personal interests and hobbies, engage in activity, provide one on one support, and notify family if unable to resolve behavior. On May 6, 2025, at 12:10 p.m., unlicensed personnel (ULP)-D stated she was not sure if R1 had dementia and thought some of his behaviors were simply because R1 wanted to get a rise out of other people. On May 6, 2025, at 12:20 p.m., ULP-E stated she thought one of the R1's primary diagnoses was dementia. On May 15, 2025, at 11:05 a.m., ULP-C stated it said in R1's chart the R1 had dementia but ULP-C didn't think it was dementia and that it was a different form of autism. On May 15, 2025, at 11:30 a.m., ULP-F stated she did not know much about the R1's health	0 450		

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 _____	C 05/06/2025

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
0 450	Continued From page 3 record or what his diagnoses were. ULP-F stated she had heard R1 had memory issues but she had not noticed any and didn't think he had dementia. On May 16, 2025, executive director (ED)-D stated she did not think R1 had dementia but that the ombudsman had mentioned once that R1 met the criteria to have frontal lobe dementia. ED-D stated she did not think R1 had any diagnosed cognitive issues. On May 13, 2025, at 1:10 p.m., R1's representative stated they had told facility management many times R1 had dementia and they had R1's doctor send a letter confirming he had a diagnosis of dementia but the facility continued to say he didn't have a diagnosis of dementia. PLAN OF CARE The licensee failed to follow the R1's plan of care and contact family if the resident had any behaviors that could not be redirected. R1's assessment dated November 27, 2024, indicated R1 had behaviors including wandering into other apartments and making inappropriate comments to others. Interventions included redirecting resident, removing resident from situation, engaging in activity, one on one intervention, notify family if unable to resolve behavior. A review of police reports indicated law enforcement responded on the following dates: -December 29, 2024, the facility called police to report R1 was being disruptive, harassing staff, and attempting to enter other resident's rooms.	0 450		

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 _____	C 05/06/2025

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
0 450	Continued From page 4 Police advised R1 return to his room. Facility documentation lacked any documentation of a police response or that family had been notified. -January 2, 2025, the facility called police for R1 playing loud music. Facility documentation indicated the executive director requested staff call police for assistance with the R1's behaviors. Facility documentation lacked evidence family was notified. -January 4, 2025, staff called police to report R1 was sexually harassing residents and refusing to go to his room. Police escorted R1 back to his room. Facility documentation lacked any documentation of a police response or that family had been notified. -January 6, 2025, staff called police to report R1 was making inappropriate sexual comments and grabbed the director by the arm. Facility documentation lacked any documentation of a police response or that family had been notified. -February 15, 2025, a visitor called police around 5:30 p.m. to report R1 was harassing other residents. Facility documentation indicated the resident's power of attorney was called at 6:00 p.m. -March 12, 2025, the facility called police after R1 had a physical altercation with another resident. Facility documentation indicated the power of attorney was notified at 6:29 p.m., and police were called at 6:33 p.m. On May 13, 2025, at 1:10 p.m., R1's representative stated they had not been told of many of the police calls made and only found out after they spoke with a responding officer after the February 15th call when the officer made a comment that they had been there a few times before for R1's behaviors. R1's representative stated they requested police records from the police department and were "floored" when they	0 450		

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 _____	C 05/06/2025

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
0 450	Continued From page 5 saw how many times officers had been called to intervene and they were never notified. R1's representative stated they would have expected to be called before police were called as it was in his plan of care. On May 14, 2025, at 9:15 a.m., R2's power of attorney (POA) stated she had only called the police on February 15th because R1 kept bothering R2 and staff were not able to assist her with removing R1. R2's POA stated she asked staff what she was supposed to do about R1's behaviors and staff said she needed to call the police so she did. R2's POA stated she didn't know R1 well at that point or else she would have tried redirecting R1 and after observing how police interacted with R1, she regretted that she called police for help. RESIDENT ALTERCATIONS The licensee failed to put interventions in place related to R1 being bullied and R1 bullying other residents. As a result, R1 had several altercations with other residents. On February 7, 2025, it was documented in R1's record "At lunch time, He went behind a resident and grabbed there shoulders and yelled boo. When they got upset he patted there (sic) head. Then the resident took there (sic) shoe off and started telling him if he got any closer they where going to hit him with the shoe. Then he laughed and left." On February 7, 2025, it was documented in R2's record that "Today the resident went after another resident with a shoe. The resident left and she said she was shaking she was so made (sic)." On February 10, 2025, CNS-A documented in	0 450		

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 _____	C 05/06/2025

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
0 450	Continued From page 6 R2's record, "Upon review of behavior documentation on 2/10/25, writer noted the following documentation from 2/7/25: "today the resident went after another resident [R1] with a shoe. The resident left and she said she was shaking she was so mad." Writer met w/ [R2] to gather details regarding incident. [R2] was able to recall details from incident on 2/7/25. States she normally arrives to the dining room around 11:15 AM and leaves between 11:45-12:00 PM. [R2] stated that she was in the dining room eating when a male tenant [R1] approached her by "slapping me on the shoulder." Stated, "No matter where I go or where I sit, he always hits me on the shoulder or puts his phone in my face with little kids on there. I couldn't handle it anymore. I took my shoe off and went after him in the dining room with my shoe. I hit him over the shoulder and he thought it was funny." Stated that he then left the dining room and she left shortly after. States, "He is a nice man but why does he pick on me?" Tenant acknowledged that she should not have hit this other tenant w/ her shoe stating, "I was just so mad." States she has not had any addt encounters since the incident on 2/7/25. States she has not been engaging in a conversation w/ this other tenant, she has been avoiding sitting at the same table as this other tenant and has been locking her door at all times. Encouraged tenant to disengage in any addt interactions w/ this other tenant that may result in a negative outcome / behaviors." R2's plan of care was updated to reflect her physical aggression towards another person with interventions of removing the resident from situation, removing other person from resident's current area, locking her apartment door, disengaging in conversation with other person if able, notify nursing/staffing/management as able. CNS-A failed to identify any interventions related	0 450		

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 _____	C 05/06/2025

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
0 450	Continued From page 7 to ongoing altercations between the R1 and R2 in the dining room and failed to review R1's plan of care after the resident admitted to hitting him. On February 11, 2025, CNS-A documented in R1's record, Upon review of behavior documentation on 2/10/25, writer noted the following documentation from 2/7/25: "At lunch time, He went behind a resident (210) and grabbed there (sic) shoulders and yelled boo. When they got upset he patted there (sic) head. Then the resident took there (sic) shoe off and started telling him if he got any closer they where going to hit him with the shoe. Then he laughed and left." Writer was unable to interview/investigate on the evening of 2/10/25 as tenant was out w/ family celebrating his birthday. Writer and fellow RN completed interview/investigation w/ [R1] around approx 1100 on 2/11/25. When asked if tenant recalled any incidents w/ any other tenants that occurred in the dining room, he declined at that time stating, "I walk in there, they all hate me." When asked if anyone has physically touched and/or hit him he replied, "Oh that one lady who is 90-something years old. I go and touch her on the shoulder and she hits me back w/ her hand or her foot." When asked for addt details he stated, "She had her shoe off and hit me." When asked for possible details on date/time, he stated, "Maybe a couple of weeks ago." When asked where he was hit he stated, "I don't remember where she hit me, if it was here or there" as he was speaking of his arms. When asked what happened next he stated, "I just left." Writer and fellow RN completed skin check and observed no bruising, abrasions, skin tears or altered skin integrity to BUE [bilateral upper extremities], head on down to lower abdomen and back area. Writer updated daughter around approx 1550 via	0 450		

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 _____	C 05/06/2025

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
0 450	Continued From page 8 telephone. Writer and fellow RN educated tenant on addt ways to communicate verbally w/ others and to avoid physical touch as others may not perceive the touch as friendly and/or positive as he gestured. Tenant was complaining of right knee pain and lower back pain at time of visit, encouraged ice pack application numerous times in which tenant denied the need for ice pack application at that time..." On February 24, 2025, CNS-A entered a care conference note in R1's record indicating R1's family expressed concern that the "incident regarding the 'shoe throwing' was 'sugar coated.'" No additional documentation was entered on the concerns or the resolution of the concerns. On February 23, 2025, it was documented in R2's record resident was sitting upstairs after lunch having a nice convection with [other resident] and [R1], when [other resident] came walking out wanting to see what they were doing and [R1] started to shake [other resident's] walker. she did not like that [R1] was doing this and stated to yell at him. she said " do I need to take my shoe off again". staff was talking with R1 trying to get him to stop and they told the resident that it was ok they are handing it. she did not say anything back and then her son-in-law happened to walk up the stairs and she went back to her room with him." Later that day, it was documented in R2's record that R2 was trying to take off her shoe and hit R1 again. No documentation about the incident was entered in R1's record. On February 26, 2025, it was documented in R2's record that R2 was "trying to take off their shoes and hit [R1]." No documentation about the incident was entered in R1's record.	0 450		

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 _____	C 05/06/2025

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
0 450	Continued From page 9 On February 27, 2025, it was documented in R2's record that R2 was "was attempting to resident [R1] with her shoe but then stated that she took her shoe off because her ankle was sore." No documentation about the incident was entered in R1's record. On March 1, 2025, it was documented in R2's record that R2 got "really upset with [R1], threatened to hit them with their shoes." It was noted she "didn't succeed. No documentation about the incident was entered in R1's record. On March 4, 2025, CNS-A reviewed R2's record and added that she had physical aggression towards another person including hitting or kicking with one of her shoes. Interventions remained the same. CNS-A failed to reassess R1 related to the shoe incidents. On March 9, 2025, it was documented in R2's record that "This morning [a resident] was walking with another resident. I was walking with her and she told the other resident " [R1] hids (sic) around all these corners and a few days ago he put his shoe in my door so I couldn't close it. So I took my shoe off and smacked him right in the head." I listened to what she had to say and then she went into her room and said thank you to me. No documentation about the incident was entered in R1's record. On March 12, 2025, it was documented in R2's record that "Resident had her shoe off and stood up and stated to staff that she was ready if she had to because another resident would not leave them alone and another resident said something to a staff member and she did not like the comment. Staff reminded this resident that it was ok and that I would take care of the situation and	0 450		

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 _____	C 05/06/2025

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
0 450	Continued From page 10 to please sit down and put her shoe back on. Resident did do this and then after Staff walked another resident away then staff was able to walk this resident back to her room while pushing another resident to her room." No documentation about the incident was entered in R1's record. On March 13, 2025, it was documented in R1 and R2's record that the resident had physically grabbed a R2 by the wrist after she threw water on him. Documentation indicated R1 approached a table of four other residents and tapped a male resident on the shoulder, when he didn't respond he put his face in another resident's face. The resident was escorted out of the dining room by a cook but when she returned to the kitchen, the resident walked back into the dining room and approached R2, who threw water on him. When the cook heard screaming, she came back out and saw R1 holding R2 up by the shoulders. Police were called and R1's daughter was notified. On March 14, 2025, it was documented in R2's record that staff visited with R2 who showed her ankle and hand to staff saying that was where R1 hurt her, kicked her, and poured a whole glass of water on her. R1 came near where R2 was sitting talking to other residents and was talking "about how [R1] "should have never been born." Telling resident "I would be embarrassed if you were my father." Writer told resident [R2] those are not nice things to say and should only say nice comments to others. Writer then escorted resident to room with [other resident]. [Other resident] wanted [other two residents] to come to [room number] for some ice cream. Resident told writer "be careful now [R1] will follow us now that we are leaving." After escorting resident to [room number], [R1]	0 450		

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 _____	C 05/06/2025

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
0 450	Continued From page 11 followed residents and staff trying to get into apartment resident yelled at [R1] to "go away and you are not welcome here." After [other resident] closed the door and locked it behind staff, resident calmed down after eating some ice cream and chatting with staff and other residents in room. Staff after a while escorted [other residents] back to their apartments." On April 29, 2025, it was documented in R1 and R2's record that [another resident] was sitting at lunch when [R1] sat next to her. [R2] told [R1] that he wasn't right in his head and told him if he kicks her, "I will put my knife in your hand". [R1] then proceeded to kick her and [another resident] yelled "Knock it off right now". [R1] then went on his phone and put it in [R2's] face. [R2] tried to smack It out of [R1's] hand. [R1] backed his phone up and started laughing. [R2] then picked up her knife and held it up and told [R1] to knock it off again. Staff told [R2] to stop and [R2] did." On April 30, 2025, RN-G documented she reviewed behavior logs from 4/29/25 to 4/30/25 and "Resident [R1] continues to have behaviors related to poking and kicking other residents. Interventions mostly successful." RN-G failed to assess the incident involving threats of a knife. No interventions were put in place regarding violence and altercations occurring in the dining room. On May 5, 2025, it was documented in R1's record that he began playing a nursery rhyme on his phone in the dining room when staff asked him to turn it down several times. Another resident became upset and "grabbed the resident [R1] by the shirt with both hands and said 'I'm going to slap you so hard you won't wake up.' The other resident let go of R1's shirt as two staff	0 450		

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 _____	C 05/06/2025

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
0 450	Continued From page 12 intervened to provide distance between the two residents and continued to provide one on one until either of them left the dining room as both were refusing to relocate." On May 13, 2025, at 1:10 p.m., R1's representative stated when they were notified of the February 7th incident, they were told no contact was ever made with R2's shoe and they only found out later that there was contact. R1's representative stated they had raised concerns that a lot of the behaviors between R1 and R2 happened during meal times when there were often no ULP staff in the dining room and that they felt there should be more supervision given the history of altercations between the two residents. On May 15, 2025, at 11:30 a.m., ULP-F stated she was working on February 7th and she was bringing another resident into the dining room and when she walked in, R1 was standing by R2 and R2 was asking him to get away but R1 was laughing and listening to his phone at a loud volume. ULP-F stated R2 took her shoe off and said to get out before she hit him with the shoe and he started to walk away. ULP-F stated she did not see any contact because she left the dining room right after and there were no other staff in the dining room at that time that she knew of. FAILURE TO ADOPT INTERVENTIONS The licensee failed to consider intervention options suggested by R1's representative and family members. Interventions suggested were not added to R1's individual abuse prevention plan or assessment.	0 450		

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 _____	C 05/06/2025

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
0 450	Continued From page 13 R1's representative provided a copy of interventions provided to the facility on April 1, 2025, to assist with R1's behavior management. Interventions included the following: -For the resident following staff or laughing at inappropriate times, the representative suggested "I laugh when I am in uncomfortable situations. It is me coping with the situation. I am curious. I tend to follow staff. Please get me busy in a activity before heading off to someone's room if I am following you." -For the resident being able to participate appropriately in activities, it was suggested the facility seat the resident in "chair I can get out of easily, sit next to leader so I can hear what is going on repeat what others are saying, Please invite me right before event so I do not have to sit and wait for activity long. My attention span varies, please use words I can understand, speak in deep tone, slowly, friendly matter. I may not remember everyone's names please do introductions every time." -For activities for the resident, it was suggested to encourage participation in "Cleaning car parts, help clearing tables, filling bird feeders, military theme activities, checking for light bulbs needing replacement, pushing grocery cart for staff delivering groceries, help setting up activities. I enjoy visiting with children and pets. I also enjoy music. I enjoy things that bring laughter. Pets could come from Humane society, Babinski, 4-H club. Children visits such as cub scouts, 4-H, school. Music performance. Military guests, nature discussion, old car club" Activities the resident enjoyed were identified as painting, name car parts, animals, and building things. Sensory items that the resident enjoyed included fidget things, things to touch, unlocking locks. Activities the resident would enjoy included bowling, balloon swat, bean bag toss, parachutes.	0 450		

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 _____	C 05/06/2025

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
0 450	Continued From page 14 Outdoor activities the resident enjoyed included "walks, gardening, bird feeders, a simple treasure hunt such as find a robin, grass, rock, etc. Could also do in building as well. Count the stairs, find a yellow door etc." -The representative also requested a reasonable accommodation related to dining room seating of "Have staff check the table height in the dining room and/or any table [R1] sits at within Edgewood Assisted Living. [R1's] body features present with very long legs and long arms. Other residents may bring their wheelchairs and walkers to sit close to a table which limits the space under the table. Therefore, review if [R1] may be kicking others under the table due to insufficient leg room under the table this accommodation may prevent [R1] from kicking or touching others with his feet." On May 13, 2025, at 1:10 p.m., R1's representative stated they had suggested many interventions to help with R1's behaviors but the facility was resistant to implementing them or found reasons why they couldn't try the interventions. On May 19, 2025, at 11:45 a.m., RN-G stated she was not made aware of the list of interventions provided by family and would have to look into how the list of interventions was implemented or not. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 630 SS=H	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 15 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a comprehensive assessment of a resident's risk of abusing other vulnerable adults with statements of the specific measures to minimize the risk of abuse for two of two residents (R1, R2), and failed to complete a comprehensive assessment of a resident's susceptibility to abuse by another individual with statements of the specific measures to minimize the risk of abuse for two of two residents (R1, R2). 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). The findings include:	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 16 The licensee failed to take immediate action to develop and implement specific measures to reduce R1 and R2's risk of bullying other residents, being bullied by other residents, and address behaviors exhibited by R1. R1 R1's diagnoses included dementia, anxiety, and hearing loss. R1's service plan dated March 28, 2025, indicated R1 received services including behavior management for wandering and physical aggression, as well as "other mental health need." R1's assessment dated May 1, 2025, indicated the resident had behaviors, including a history of wandering into other resident's apartments, touching other residents, and kicking and poking at other residents. R1 was able to communicate but may not be consistent due to dementia. Staff were to anticipate needs and advocate for R1. R1 was noted to have moderately impaired cognition with memory problems. R1 was not able to recognize that he was making others uncomfortable due to his dementia. Interventions for the R1's behaviors included approaching calmly, redirecting, removing resident from situation, offering to go for a walk, offer a snack, validate feelings, engage in conversation about personal interests and hobbies, engage in activity, provide one on one support, and notify family if unable to resolve behavior. R1's individual abuse prevention plan (IAPP) included a section about R1's risk to abuse other vulnerable adults. The assessment failed to identify R1's behaviors towards other residents	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 17 and was not individualized to the resident. The IAPP included staff were to redirect R1 when permission was not given by another resident to enter their apartment. Staff were to verbally redirect R1 verbally or physically and validate his feelings. The IAPP included a section about R1 being at risk for being abused. The assessment failed to identify the ongoing threats and physical aggression R1 was subjected to over a period of several months and was not individualized to the resident. R2 R2's diagnoses included anxiety. R2's assessment dated April 25, 2025, indicated R2 was at risk to be abused and interventions included verbally redirecting the resident, allowing them time to express concerns, listening to the resident, validate feelings, verbally redirect to alternative locations, physically escort the resident to apartment and ensure door is locked, provide reassurance. If unable to resolve, nursing and or family were to be notified right away. R2 was noted to be at risk to abuse other vulnerable adults and interventions were the same as those identified under R2's risk to be abused. R2 had behaviors including agitation and physical aggression towards another person including hitting or kicking with one of her shoes. The assessment failed to identify R2's verbal abuse towards R1 and what interventions were in place to prevent further verbal altercations between the two residents. R2's record contained several documented instances of R2 threatening to hit another resident with her shoe, threatening to use a knife against another resident, and making verbal comments and insults to R1.	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 18 Incidents: R1's progress notes contained the following: JANUARY: Multiple instances of R1 playing his phone on a loud volume or trying to get other residents or staff to look at something on his phone, trying to pet another resident's dog, entering other apartments without permission, following staff while they were working, touching items on the medication cart, touching other residents, attempting to enter the dining room while staff were setting up for meals or serving meals were documented. Documentation indicated other residents had told R1 to go away and threatened to call the police on him. R1 was noted to have knocked on another resident's door that had a welcome sign on it. Interventions used by staff included ignoring the resident, walking away and hiding from the resident, telling the resident his behavior was inappropriate, or redirecting the resident back to his room. On January 16, 2025, clinical nurse supervisor (CNS)-A wrote that R1's plan of care was updated and included behaviors related to sexual behaviors but the trigger for behaviors was unknown. Interventions included redirection, removing the resident from situations, offering to go for a walk, offer snack, offer fluids, validate feelings, talk about personal interests or hobbies, engage in activity, provide one on one support, and notify family if unable to resolve behavior. The note indicated R1 wandered into other apartments but the trigger was unknown. Interventions included redirection, removing the resident from situations, offering to go for a walk, offer snack, offer fluids, validate feelings, talk	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 19 about personal interests or hobbies, engage in activity, provide one on one support, and notify family if unable to resolve behavior. The licensee failed to implement interventions or assess R1's behaviors related to following staff, playing loud music, or trying to pet other resident's animals, The licensee failed to assess other residents making comments towards R1 like threatening to call police or yelling at him to go away. FEBRUARY: Multiple instances of R1 touching other residents, preventing staff members from passing through, trying to enter other resident's rooms or following other residents into their rooms, touching things on the medication cart, entering the kitchen, trying to pet a dog were documented. In addition, a family member of another resident called police after R1 would not leave the other resident alone. Interventions used by staff included ignoring R1 and telling him they had a job to do, telling the resident to go back to his room, and telling the resident to leave, telling the resident to stop doing something, and telling the resident he didn't have consent to touch others. During seven of the documented behaviors, a staff member walked with R1 and provided distraction by talking about the weather or other topics, which was successful. During two additional documented behaviors, staff asked R1 to get some more steps in, which was successful. On February 10, 2025, a care conference was held to review R1's behaviors and new interventions were reviewed including asking the tenant if he liked the Big Bang Theory, ask how	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 20 he is feeling, having him check light bulbs in the common areas to see if any were burnt out, inventory chairs in the dining room, providing joke cards to staff so they could share jokes with the resident, have staff show the resident funny videos, post a hard hat zone sign to prevent entering other apartments as the resident had a history of working in a setting where he knew he could not enter without a hard hat. The facility was to provide additional dementia training to staff related to the resident. The licensee failed to add the interventions to the R1's individual abuse prevention plan or ensure staff were using them when R1 exhibited behaviors. The licensee failed to identify interventions related to documented behaviors including preventing staff members from passing through, trying to enter other resident's rooms or following other residents into their rooms, touching things on the medication cart, entering the kitchen, trying to pet a dog area were documented. On February 13, 2025, registered nurse (RN)-G documented in R1's record, "Behaviors reviewed. Will continue with current plan of care. Behavioral logs from 2/6/25 to 2/13/25 sent to POA [power of attorney]." On February 24, 2025, clinical nurse supervisor (CNS)-A wrote she added additional behavior monitoring services for R1's behavior of using touch as a form of communication towards others that don't want to be touched. The trigger for R1's behavior was noted to be unknown. Interventions included verbally redirecting the resident to not touch others and encouraging the resident to use verbal communication with others. A care conference was held that day and it was	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 21 discussed to add additional one on one support for R1, consider moving R1 to the first floor, and additional training for staff. On February 28, 2025, CNS-A wrote R1's plan of care was updated to reflect R1 having hearing difficulty and that R1 was at risk to abuse himself due to his unspecified mild dementia with anxiety. R1 was noted to not be able to recognize that he was making others uncomfortable. Behavior interventions were added to engage in conversation about personal interests and hobbies including deer, cats, dogs, animals, outdoor activities, hunting, fishing, music, air force, mechanical conversations, tracking steps, Big Bang Theory, family members. The licensee failed to implement interventions or assess R1's behaviors related to preventing staff members from passing through, trying to enter other resident's rooms or following other residents into their rooms, touching things on the medication cart, entering the kitchen, or trying to pet a dog. MARCH: Multiple instances of R1 attempting to enter other resident's rooms, following residents or staff into rooms, trying to enter the kitchen, "antagonize" other residents and touch other residents foot with his foot, interrupting church services and activities, touch residents during meal times, trying to eat food off other resident's plates during meals, or the resident trying to sit with a group of residents who did not want to sit with him at meal times were documented. Documentation indicated R1 got into a verbal argument with another resident which resulted in R1 and another resident saying things like "idiot",	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 22 "go home", and "shut up." Another incident occurred between the two residents where R1 physically grabbed the other resident after she threw water at him during meal time and police were called to intervene. On one occasion, staff attempted to redirect R1 after he was bothering other residents, but he was "dismissive of staff even after trying to engage in conversation about his steps..." During another behavior, RN-G was summoned to the dining room by dietary staff due to R1's behaviors. R1 was sitting at a table with four other residents and observed to be kicking at them. RN-G attempted to redirect R1 but R1 refused to go with her. RN-G was unable to redirect R1 from the dining room and called his daughter. Other documentation indicated staff struggled to redirect R1. Interventions used included telling R1 to stop or not do the behavior, keep his hands to himself, talk about weather, telling him to not say things like that, asking R1 to get more steps in, telling him to respect what other residents are saying, telling R1 violence is not the answer, taking R1 for a walk, or telling R1 it was rude to bang on doors. Only one instance of staff telling R1 an area was off limits due to being a hard hat zone was documented. The intervention was documented to be successful. On March 3, 2025, a care conference was held to review R1's plan of care. R1's support team "requested trauma be added to the resident's plan of care for bullying and harassment." R1's support team requested the facility call 911 to initiate a police report regarding bullying and harassment that the tenant had endured at the facility. CNS-A and the executive director	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 23 "initiated the phone call shortly after the care conference ended." The licensee failed to add trauma to the resident's plan of care for bullying and harassment. The licensee submitted a MAARC report on March 4, 2025, related to R1 being bullied but did not take any further action. On March 18, 2025, a care conference was held and the R1's care team asked what was being done for trauma informed care due to the trauma R1 was experiencing at the facility. They discussed having staff and or other residents greet R1 with a handshake and concerns were raised that staff were inviting R1 out to the dining room despite R1 having a preference for eating in his room. On March 27, 2025, RN-G documented the resident had five recent behaviors related to physical aggression, touching other residents, and being disruptive during a community activity. "Interventions mostly unsuccessful." RN-G failed to identify any new interventions for R1's behaviors. On March 28, 2025, the facility updated R1's medical provider that "For the last 30 days, the resident has had behaviors related to using touch as a form of communication towards others that do not want to be touched, wandering into other resident's apartments, kicking and poking at others. The following order was received from [doctor] Noted. Continue conservative methods. RN updated." On March 28, 2025, RN-G reviewed R1's behaviors and noted one incident related to taking food off other resident's plates at meal times. RN-G failed to identify any interventions related to the behavior. RN-G updated R1's plan of care to address the behavior of kicking and poking at other residents with triggers identified as wanting to gain attention from others, lower leg pain, wanting to be	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 24 acknowledged. Interventions included ensuring R1 had space to stretch out their legs, offer ice packs for pain, go for a walk, encourage to get steps in, allow resident to express feelings, verbally redirect to not touch others, remove from situation, encourage the resident to use verbal communication, talk about interests and hobbies. On March 30, 2025, it was documented R1 interrupted an activity when he frequently shouted out bingo. Other residents were noted to have told R1 to "get lost". Staff told the resident to keep his hands to himself. Another resident called R1 an "asshole" and another resident "grabbed [R1] by the collar." Staff documented their intervention was telling the resident "we need to keep our hands and words to ourselves." On March 31, 2025, RN-G documented she reviewed R1's behavior logs from the last three days and R1 had two behaviors related to using touch as a form of communication towards others that do not want to be touched. One behavior of kicking another resident and three documented behaviors of attempting to enter other resident rooms were reviewed. "Interventions partially successful." RN-G failed to identify any new interventions related to R1's behaviors after current interventions were not always successful. The licensee failed to implement interventions or assess R1's behaviors related to the resident attempting to enter other resident's rooms, following residents or staff into rooms, trying to enter the kitchen, interrupting church services and activities, trying to eat food off other resident's plates during meals, or the resident trying to sit with a group of residents who did not want to sit with him at meal times. The licensee failed to identify new interventions related to R1	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 25 touching other residents after it was documented suggested interventions were often not effective. APRIL: R1's medical record included multiple instances of R1 trying to sit next to two residents who had expressed a preference to not sit by R1 during meals, R1 trying to enter the room of another resident with a dog trying to pet her dog, trying to enter other resident rooms/following residents into rooms, banging on the wall, making inappropriate comments to staff, interfering in activities, putting his phone in peoples faces, trying to enter the kitchen Interventions used included asking R1 to stop, redirecting the conversation, telling him his behavior is not nice, telling R1 his behavior makes others uncomfortable, telling the resident he needs permission to touch someone, ignoring the resident, and asking him to move. Successful interventions used included redirecting the conversation to talk about the weather and offering to walk with the resident. In one behavior note, staff documented R1 asked her if she was talking about him to another resident. Staff wrote they "responded politely 'It's private, and isn't anyone's business but I wasn't talking about you" he didn't like that answer, and was getting snippy." On April 3, 2025, RN-G documented R1's "Behavior logs reviewed. Resident had 3 documented behaviors related to wandering. Interventions partially successful. Resident had 4 documented behaviors related to using touch as a form of communication towards others that do not want to be touched by poking and kicking at other residents. Interventions mostly failed. PCP	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 26 notified." RN-G failed to identify any new interventions. On April 7, 2025, RN-G reviewed R1's behavior logs and two behaviors related to using touch as a form of communication, interventions were noted to be "mostly successful." On that same day, R1 was noted to have tried to enter another resident's room. On April 8, 2025, staff documented R1 entered another resident's apartment without permission trying to pet the resident's dog. On April 9, 2025, RN-G documented she reviewed R1's behaviors from April 8th and 9th and no behaviors had been documented. On April 10, 2025, RN-G wrote R1 had a behavior of making inappropriate comments to others and interventions were partially successful. There were two documented behaviors related to touching others but interventions were noted to be successful. The resident had a behavior of wandering into other apartments and the intervention was partially successful. On April 19, 2025, staff documented R1 had made an inappropriate comment to another resident and "staff attempted to intervene by asking resident if he wanted to go on a walk. Resident declined. Staff asked R1 t if he wanted to go outside to look for deer. Resident declined. Staff asked resident if he wanted to go to his room and listen to music. Resident declined. Staff asked resident how many steps he was at, and resident ignored staff and continued to try to press the other residents into telling him what they weighed. Staff were unable to redirect."	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 27 On April 21, 2025, CNS-A wrote R1's "Behavior trends reviewed over the weekend and into today. Multiple instances where tenant was touching others. Interventions that were successful or partially successful include the following: verbal redirection/orientation, maintaining line of-sight supervision of resident as much as possible. Other interventions w/ success include the following: validating feelings, listen to concerns, ensure whereabouts, provide close supervision. Two instances w/ failed verbal redirection. Staffing is doing a good job w/ intervening overall. No changes at this time." Later that evening, staff documented R1 was disruptive at dinner, trying to steal their desserts and other residents threatened to call the police. During evening cares, R1 attempted to enter another resident's room while she was getting ready for bed. Staff had to repeatedly ask the resident to leave before he did. On April 22, 2025, CNS-A wrote that R1's "behavior trends reviewed- updated daughter via telephone..." On April 24, 2025, RN-G wrote that "[R1] continues to have behaviors related to wandering into or to other resident rooms/ staff kitchen, poking or touching others, inappropriate comments towards staff and other residents, taking deserts off of other resident's table and personal space of others. Interventions mostly successful." Later that evening, staff documented R1 was attempting to poke other residents sitting in a common area and the residents asked him to stop. The staff wrote, "...Staff attempted to redirect R1 multiple times. Staff asked resident if he wanted to go on a walk, resident declined. Staff asked resident if he wanted to look at the goose that was outside the window, resident	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 28 declined. Staff asked resident about how many steps he had and resident declined to answer. R1 continued to attempt to poke other residents, and staff members, as well as grab their shoulders, while calling residents and staff "Idiots". Staff attempted multiple redirections and all failed. Staff had no other choice but to escort the other residents sitting in the area to their rooms, and resident followed them down the hallway until he reached his apartment." On April 25, 2025, RN-G reviewed R1's behaviors and noted two behaviors related to verbal aggression towards other residents. "Interventions mostly ineffective." RN-G failed to identify any new interventions. Later that evening, the resident approached a staff member who was sitting in her car in the parking lot. "...Staff locked the car doors and rolled up the windows on the car. R1 then began trying to open the car door by repeatedly pulling on the car door handle. Staff did not respond to this behavior, resident then walked away." On April 29, 2025, staff documented R1 sat next to a resident who had previously expressed not wanting to sit next to R1 at meals. The resident told R1 he wasn't right in the head and if he kicked her, "I will put my knife in your hand." R1 proceeded to kick the other resident, who yelled at him to knock it off. R1 put his phone in the resident's face and the other resident tried to "smack it out of his hand." The other resident "picked up her knife and held it up and told [R1] to knock it off again." Staff told the other resident to stop and she did. On April 30, 2025, RN-G wrote she reviewed R1's behavior logs from 4/29/25 to 4/30/25. "Resident continues to have behaviors related to poking and	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 29 kicking other residents. Interventions mostly successful." RN-G failed to assess the incident involving a knife and another resident. The licensee failed to implement interventions or assess behaviors related to R1 trying to sit next to two residents who had expressed a preference to not sit by R1 during meals, the resident trying to enter the room of another resident with a dog trying to pet her dog, trying to enter other resident rooms/following residents into rooms, banging on the wall, making inappropriate comments to staff, interfering in activities, putting his phone in peoples faces, or trying to enter the kitchen. MAY: R1's medical record contained multiple instances of R1 wandering into rooms, poking/bothering other residents, bothering other residents during meal time, walking into the kitchen, playing loud music in other peoples' faces were documented. Interventions used included telling the resident not to do something, redirecting the resident, telling him it's not ok to kick people, asking the resident to leave, and telling the resident his behavior was inappropriate. On May 1, 2025, staff documented they had to call for a nurse to assist in the dining room due to R1 moving to the same table as a group of residents that had previously expressed they did not want to sit with R1 during meals. Later that day, RN-G reviewed R1's behavior documentation and noted "resident continues having behavior related to inappropriate comments towards other residents and poking another resident." RN-G failed to identify any interventions and failed to identify interventions	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 30 related to keeping increasing supervision during meals to keep R1 separated from other residents who he has had ongoing conflict with during meals. On May 2, 2025, RN-G reviewed R1's behavior logs and noted he had two documented behaviors related to calling another resident an asshole. "Interventions mostly failed." RN-G failed to identify any new interventions. On May 5, 2025, RN-G documented R1 started playing a nursery rhyme on his phone during meal time and staff asked him to turn it down as it was being disruptive. The resident complied but as soon as staff walked away, he began playing the song again. Another resident became upset and "grabbed [R1] by the shirt with both hands and said "I'm going to slap you so hard you won't wake up." The other resident then let go of R1's shirt as staff intervened by two staff intervened to provide distance between the two resident's and continued to provide one on one until either of them left the dining room as both were refusing to relocate." On May 6, 2025, RN-G reviewed R1's behavior documentation and noted the "...R1 continues to have behaviors related to wandering into other resident rooms, inappropriate language and disrupting other resident at meal times by play videos on their phone at a disruptive volume. Interventions successful." The licensee failed to implement interventions or assess the R1's behaviors related to wandering into rooms, bothering other residents during meal time, walking into the kitchen, and playing loud music in other peoples' faces.	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 31 On May 6, 2025, at 12:10 p.m., unlicensed personnel (ULP)-D stated R1 had severe behaviors and it seemed like lunch and dinner was when he had the most behaviors. ULP-D stated she thought the behaviors were because R1 was bored and was trying to get a rise out of people. ULP-D stated it seemed like a lot of residents didn't like R1 and it seemed he was "targeted" by a group of ladies who bully him and it triggered him to have behaviors. ULP-D was asked what interventions should be used for R1 and she stated they usually redirect the resident. On May 6, 2025, at 12:20 p.m., ULP-E stated R1 had behaviors where he'd kick or call a group of ladies names and wasn't sure why R1 did it. ULP-E was asked what interventions should be used to manage R1's behaviors and ULP-D stated redirection, but noted that sometimes it didn't work. On May 14, 2025, at 11:30 a.m., CNS-A was asked why interventions suggested by R1's family were not always implemented and why many behaviors were not reflected in his assessments, and why interventions were not identified for all R1's behaviors and CNS-A stated, "I don't have a good answer for you." On May 15, 2025, at 11:05 a.m., ULP-C was asked about what interventions should be used for R1 and she stated they were directed to walk away, ignore R1, explain to him I don't want you to grab my arm, or redirect the resident. ULP-C stated the interventions were not always successful and with redirection sometimes he would get more angry. ULP-C stated management was aware of the bullying between R1 and R2 and they were just told to keep them separated, which was not successful. ULP-C	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 32 stated management was also aware that was not a successful intervention. On May 15, 2025, at 11:30 a.m., ULP-F stated she had witnessed R1 and R2 have ongoing behaviors towards each other. ULP-F stated it was kind of a back and forth thing between R1 and R2 and other residents would talk mean things about R1. ULP-F was asked what interventions were used for R1's behaviors and she stated R1 generally called for someone else to help as R1 didn't listen to her. ULP-F stated the only intervention she was told was to ask him to please move "which never works for me." ULP-F stated they would try to have staff in the dining room but if there were three staff working, two would be doing the med cart and the third would have to bring people to and from the dining room so they couldn't always be in there. ULP-F stated she thought R1 said mean things to other residents just to get a rise out of them. On May 19, 2025, at 11:45 a.m., RN-G stated she would have to look into it and see if the times R1 was threatened by R2 should have been entered into his record, not just R2's. RN-G stated it would have been communicated to nursing but as far as making it into the chart, she'd have to see how they go about that. RN-G stated all resident behaviors should have interventions in place and would have to look into why some of R1's behaviors were not mentioned in assessments or the IAPP. RN-G stated they had a lot of interventions in place for R1. The licensee's undated Individual Abuse Prevention Plan policy indicated an individual abuse prevention plan would be developed for each new resident. The resident and or representative would participate in the	0 630		

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 _____	C 05/06/2025

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
0 630	Continued From page 33 development of the individual abuse prevention plan to the full extent possible. It would contain an individualized assessment of the resident's susceptibility to be abused by other individuals, including other vulnerable adults, the resident's risk of abusing other vulnerable adults, the resident's risk of abusing self, and statements of the specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 630		
02350 SS=G	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one resident (R1) was treated in a courteous, respectful, and dignified manner when staff threatened the resident he would go to jail if he didn't stay in his room. 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 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	02350		

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 _____	C 05/06/2025

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
02350	Continued From page 34 situation has occurred only occasionally). Findings include: R1's diagnoses included dementia, anxiety, and hearing loss. R1's service plan dated March 28, 2025, indicated the resident received services including behavior management for wandering and physical aggression, as well as "other mental health need." R1's assessment dated May 1, 2025, indicated the resident had behaviors, including a history of wandering into other resident's apartments, touching other residents, and kicking and poking at other residents. R1 was able to communicate but may not be consistent due to dementia. Staff were to anticipate needs and advocate for R1. R1 was noted to have moderately impaired cognition with memory problems. The assessment in effect at the time of the incident dated November 27, 2024, indicated R1 had a history of wandering, was forgetful and had mild dementia. Police records indicated police were called to the facility on January 6, 2025 to respond to a resident disturbance. R1's progress notes indicated on January 6, 2025, at 4:42 p.m., an unlicensed personnel wrote that R1 came out by the medication cart around 4:35 p.m. and "when staff came upstairs, they saw [executive director] talk to [R1] about not bothering med tech while they're passing meds. [R1] then started playing videos on his phone at full volume. [executive director] then took	02350		

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 _____	C 05/06/2025

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
02350	Continued From page 35 resident's phone away and said she would (give it back) if he went back to his room. [R1] then started grabbing [executive director] by the arm, and around her whole body trying to get his phone back. R1 then got his phone back and called all the staff "crazy." At 7:00 p.m., unlicensed personnel (ULP)-C was charting when R1 "came on the side of me and was blasting his phone. I did not say anything and kept charting. [R1] grabbed my arm and [staff member] redirected him. So I got up and went and hid in the bathroom." ULP-C documented at 9:20 p.m. that she was helping executive director (ED)-D "walk [R1] back to his room. [R1] threw his hands down and punished (sic) me on my wrist. My worst (sic) was turning red after it happened. I just backed up and tried to help [ED-D] from a distance." Another ULP documented at 9:26 p.m. that "Staff was called upstairs to try get [R1] back to his room. When staff got upstairs, they were in the hallway trying to redirect him back to his room. I walked up to them and stated, "[R1] let's go back to your room" in which he replied "we? are you coming with me?" In which I stated no, and that question was inappropriate. Staff was able to get R1 back in his room after a couple minutes of him resisting staff." R1's record lacked documentation of police responding to the facility. A police report dated January 6, 2025, indicated officers were called by facility staff for a disturbance and that R1 was making inappropriate sexual comments and grabbed a staff member. ED-D reported to officers that R1 had been causing problems at the facility for several weeks. R1 was reported to make inappropriate comments to staff and play loud videos on his phone and would put them in staff's faces. ED-D reported that she had asked R1 to go to his room because he was causing a	02350		

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 _____	C 05/06/2025

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
02350	Continued From page 36 disturbance but he refused so she decided to take his phone from him and that she would return it if he went to his room. R1 demanded his phone back and she "told him to go to his room as she put the phone behind her back. [resident] proceeded to grab [ED-D] by the right arm with his left hand and reach around her back with his right arm." ED-D reported being nervous as he had not been physical before and was right in her face. R1 told ED-D to "give me my damn phone" and she complied. The resident was back in his room by the time officers arrived. One of the officers noted it was "clear he is suffering some kind of cognitive issues. His behavior is reminiscent of a teenage male." The officers left the facility but came back because the resident left his room and "began bothering the staff members while refusing to return to his room." The police report indicated the officer told the resident he could arrest him for disorderly conduct and the resident "laughed and asked why and didn't seem to comprehend the severity of the situation."Another officer and ED-D came to the apartment and explained to the resident he needed to stop his behavior and to stay in his room for the remainder of the night. This took some time for [resident] to agree or understand what he needed to do. Officers stood by outside of the apartment for awhile to make sure [resident] stayed there. [Resident] came out of his room multiple times, showing his videos and giggling and it would take repeated orders from Officers for him to go back into his room. At one point Officer [name] had to warn [resident] that if he didn't stay in his room, he would arrest him. [Resident] still didn't seem to comprehend why but went back into his room. Officers left the facility and a few minutes later were called back because [resident] exited his room and was causing a disturbance again. Officers returned	02350		

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 _____	C 05/06/2025

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
02350	Continued From page 37 and convinced [resident] to go back into his room. Police body camera footage was reviewed. Footage dated January 6, 2025, at 6:09 p.m., showed the following: -An officer walked down the hallway, R1 was outside of his door and ED-D was in the doorway of the resident's room. R1 can be heard asking so you guys are still downstairs? You guys are still downstairs? A voice off camera replies we're always downstairs. The resident replies oh, who's that, the police department? You talking to her? The officer replies and tells the resident to go to his room. R1 replies ok, alright, I'll make everybody happy and come into my room and laughs. The officer is heard asking what did he do now? ED-D replies that the resident just won't listen and he came out and he was going to go down and talk to these two. R1 says all I wanted to do is walk around a little bit and come back to my room. The officer replied that we agreed you were staying in your room. R1 says all I wanted was a little exercise. ED-D says we just talked about this, we said you need to stay in your apartment tonight. R1 replies well tonight, yeah well all night? ED-D replies, yes so why don't you do that? R1 asks do what? ED-D replies stay in your apartment. R1 says well I will like I said I just have to get out just one time here a little bit and walk around. The officer says no, go sit down, [resident.] The resident replies huh? The officer repeats go sit down. R1 replies I will. ED-D says you're done walking around for tonight. R1 replies ok. ED-D says tomorrow morning is another day you can walk around. The officer says again to go sit down. R1 replies I will, I gotta lock my door. The officer repeats [R1] go sit down. ED-D offers to lock the resident's door and the resident walks to a chair in his room. ED-D says good night and pulls the door shut and looks back into the room.	02350		

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 _____	C 05/06/2025

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
02350	Continued From page 38 R1 begins to laugh and says what's the matter? The officer repeats go sit down [resident.] R1 says I will, you have to see me sit down? The officer says go sit down [resident]. R1 replies I can't walk around? Both the officer and ED-D tell the resident to go sit down. The resident sits down and says are you happy? ED-D tells the resident you just need to stay here the rest of the night do you hear me? Stay here the rest of the night, thank you. R1 replies oh I will. Police body camera footage dated January 6, 2025, at 6:14 p.m. showed the following: -As the officer walked down the hallway, R1 was standing outside the door of his room, holding his phone and playing a video on his phone. R1 says do you want to see it? The officer replies nope, I do not. Turn it off dude, turn it off. Go in your room, sit down. [R1], no one wants to see that, [R1]. ED-D says stay in your room now. R1 walks into his room and says OK...maybe, with a laugh, and starts to shut the door. ED-D says it's either you stay in there or you can go to jail, it's your choice. R1 replies no, don't do that. ED-D says, that's right. The door shuts and the footage ends. On May 6, 2025, at 10:40 a.m., R1 stated "nobody likes me" and that he "just tries to be friendly and they all just hate me." R1 stated "people hate me so they call the police." On May 15, 2025, at 11:10 a.m., unlicensed personnel (ULP)-C stated the guidance they had from ED-D was to call the police if R1 touched staff and they didn't want it to lead to anything else. ULP-C stated earlier in the day on January 6, 2025, R1 had been playing his cell phone loudly and disturbing other residents so she went and got ED-D. ULP-C stated ED-D told R1 if he kept playing things on his cell phone loudly, she	02350		

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 _____	C 05/06/2025

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
02350	Continued From page 39 would take his phone, which she eventually did. ULP-C stated R1 grabbed ED-D to try get his cellphone back and ED-D agreed to give the cell phone back if R1 went to his room. ULP-C stated the police showed up later and had to keep coming to tell R1 to stay in his room. On May 14, 2025, at 11:30 a.m., clinical nurse supervisor (CNS)-A stated it was an unfortunate incident that had happened and it could have been handled a little differently and family should have been notified versus summoning police. CNS-A stated it would not be their normal protocol to have law enforcement as a behavioral intervention. CNS-A stated the language used by ED-E towards R1 was threatening. On May 16, 2025, at 9:30 a.m., ED-D stated she couldn't recall making the comments to R1 on January 6, 2025. ED-D stated she was told by corporate leadership and a facility registered nurse (RN) manager that police needed to be called as an intervention for R1. ED-D stated she was told by corporate leadership that if R1 didn't stop his behaviors to call police to have him arrested. ED-D stated she didn't make any threats to R1 and she was doing everything in her control to calm down the situation with R1 and she would "absolutely never" threaten R1 or a staff member and that's "not who I am." On May 19, 2025, at 11:45 a.m., RN-G denied giving direction for staff to call police as an intervention but thought there might have been some guidance from corporate staff. RN-G stated calling police to intervene with behaviors wouldn't be something they typically do and that they should try to provide other interventions first. No further information was provided.	02350		

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 _____	C 05/06/2025

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
02350	Continued From page 40 TIME PERIOD TO CORRECT: Seven (7) days.	02350		
02360	144G.91 Subd. 8 Freedom from maltreatment Residents have the right to be free from physical, sexual, and emotional abuse; neglect; financial exploitation; and all forms of maltreatment covered under the Vulnerable Adults Act. This MN Requirement is not met as evidenced by: The facility failed to ensure one of one residents reviewed (R1) was free from maltreatment. Findings include: The Minnesota Department of Health (MDH) issued a determination maltreatment occurred, and the facility was responsible for the maltreatment, in connection with incidents which occurred at the facility. Please refer to the public maltreatment report for details.	02360	No plan of correction required for this tag.	
02480 SS=F	144G.91 Subd. 20 Grievances and inquiries Residents have the right to make and receive a timely response to a complaint or inquiry, without limitation. Residents have the right to know, and every facility must provide the name and contact information of the person representing the facility who is designated to handle and resolve complaints and inquiries. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to investigate and respond to a grievance of one of one residents (R1) reviewed	02480		

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 _____	C 05/06/2025

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
02480	Continued From page 41 for grievances. R1's family reported concerns about R1 being bullied by several other residents at the facility. The licensee failed to investigate the allegations and take action to resolve the grievance. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included dementia, anxiety, and hearing loss. R1's service plan dated March 28, 2025, indicated the resident received services including behavior management for wandering and physical aggression, as well as "other mental health need." R1's assessment dated May 1, 2025, indicated the resident had behaviors, including a history of wandering into other resident's apartments, touching other residents, and kicking and poking at other residents. The resident was able to communicate but may not be consistent due to dementia. Staff were to anticipate needs and advocate for the resident. The resident was noted to have moderately impaired cognition with memory problems. R1's assessment lacked any documentation on bullying or concerns with the resident being bullied or bullying other residents.	02480		

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 _____	C 05/06/2025

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
02480	Continued From page 42 R1's progress notes indicated he had several interactions and altercations with at least three other residents over a period of several months. Care conference documentation indicated R1's family had brought up concerns with the resident being bullied. The licensee's grievance log included a grievance dated March 18, 2025. The grievance submitted by R1's power of attorney read, "[Resident] has been bullied for months now. This has been brought up in multiple meetings with Edgewood staff and Management but nothing is being done. We have asked that it not only be addressed with the residents bullying [resident], but also be addressed with the staff that allow it to continue. We have asked that bullying be added to [resident's] care plan as well and this has still not happened. We have witnessed this bullying ourselves, we have written eyewitness accounts that were requested by [clinical nurse supervisor] and nothing has been done or documented about those. We have also been contacted by multiple family members of other residents telling us their accounts of [resident] being bullied. Most recently a family member of a resident calling [resident] a loser and staff doing nothing about it. All of this has created a lot of trauma for [resident] and has made him more depressed and uneasy just being in the facility." The requested resolution was for staff to be trained immediately on how to handle bullying and the resident's care plan updated to help protect the resident against bullying. It was requested residents need to be addressed and held accountable for bullying. On April 3, 2025, licensed assisted living director (LALD)-B signed the grievance form. An undated, unsigned, Resolution to Grievance form about bullying read, "Bullying is not permitted at	02480		

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 _____	C 05/06/2025

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
02480	Continued From page 43 Edgewood. In order to properly address these issues, we need the names and dates of incidents and what exactly was said or done. For example, what family member of which resident called [resident] a loser and when, where, and what time. All staff have been trained. Please provide specific details. In addition, we have suggested a number of interventions in the past to integrate [resident] into the community such as walks, watching the deer, and personal interaction with staff. This has not been successful. We have actively asked for additional suggestions for interventions with [resident] and continue to request that the family assist us in providing suggestions to allow [resident] to fully integrate into the facility. Staff have received many types of training that deal with addressing behaviors, abuse, interventions, effective communication, understanding trauma informed care, and most recently resident bullying. Residents were also invited to attend an in person training about bullying." The licensee failed to investigate the bullying allegations or update the resident's individual abuse prevention plan to address that the resident was being bullied by other residents. On May 6, 2025, at 10:40 a.m., R1 stated sometimes other residents told him to go back to his room and that it seemed like "they just don't like me around." R1 stated "nobody likes me" and that he "just tries to be friendly and they all just hate me." R1 stated "people hate me, so they call the police." On May 6, 2025, at 12:10 p.m., unlicensed personnel (ULP)-D stated R1 was sometimes targeted by a group of other residents and they bully him and make unprovoked rude comments	02480		

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 _____	C 05/06/2025

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
02480	Continued From page 44 to R1 like no one wants you here, you belong in the looney bin, and to go away. ULP-D stated it seemed like R1 was targeted by the group of residents and they would bully R1 until it triggered him. ULP-D stated it seemed like the residents didn't like R1. On May 13, 2025, at 1:10 p.m., R1's representative stated they had brought up the grievance due to ongoing bullying of the resident and had not heard anything back on a resolution. R1's representative stated the facility was aware R1 was being bullied and should have been able to determine what was going on between the resident and the group of other residents. On May 6, 2025, at 12:20 p.m., ULP-E stated there had been a couple times she was aware of where a group of other residents were calling R1 names and telling him to go away and not sit there. On May 15, 2025, at 11:05 a.m., ULP-G stated she had witnessed times where a group of residents would initiate bullying of R1. On May 15, 2025, at 11:30 a.m., ULP-F stated there were incidents where a group of residents would start bullying R1. On May 15, 2025, at 11:40 a.m., clinical nurse supervisor (CNS)-A stated it was an unfortunate situation between R1 and some other residents and there was some bullying in the building. CNS-A stated she didn't think anyone understood how much work the facility had put in to help the situation for R1 and all the other residents to make everyone feel safe and were trying to intervene as much as they could. CNS-A stated they were not staffed to provide one on one care	02480		

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 _____	C 05/06/2025

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
02480	Continued From page 45 and R1 was requiring a lot of one on ones to prevent bullying or negative interactions and they were trying to protect him from any bullying. On May 15, 2025, at 2:15 p.m., licensed assisted living director (LALD)-B confirmed the grievance was not investigated because they were waiting for family to provide details on bullying R1 was experiencing. The licensee's Resident Complaint/Grievance Resolution policy dated March 2023, indicated staff would take all necessary actions to resolve a complaint or grievance that a resident and or resident representative has reported. A prompt response to the resident ' s complaint or grievance would be given to the resident verbally, and if desired, in writing. Complex problems may require time to resolve and some problems may not be able to be resolved. Whatever the case, residents will be given a reasonable explanation for the action taken on their behalf. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02480		