July 25, 2023

Licensee
Edgewood Sartell, LLC
677 Brianna Drive
Sartell, MN 56377

RE: Project Number(s) SL26585015

Dear Licensee:

On July 18, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 22, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 651-281-9796

PMB

Electronically Delivered

June 20, 2023

Licensee
Edgewood Sartell LLC
677 Brianna Drive
Sartell, MN 56377

RE: Project Number(s) SL26585015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 22, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

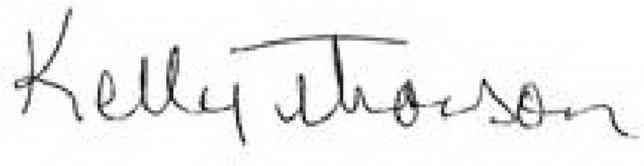
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	26585	A. BUILDING: _____ B. WING _____	05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD SARTELL LLC	677 BRIANNA DRIVE SARTELL, MN 56377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#26585015 On May 15, 2023, through May 22, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 87 active residents; 86 of whom were receiving services under the Assisted Living Dementia Care license. An immediate correction order was identified on May 19, 2023, at 12:30 p.m., issued for SL26585015, tag identification 1290. On May 19, 2023, at 3:20 p.m., immediacy of correction order 1290 was removed as confirmed by evaluation supervisor, however, non-compliance remains at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 15, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the	0 485		

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0 485	Continued From page 2 recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living With Dementia Care contract did not require any resident to include and pay for meals as a part of their assisted living package fee. In addition, the licensee failed to ensure menus were available to the residents at least one week in advance. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 15, 2023, at 11:26 a.m., during a tour of	0 485		

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0 485	Continued From page 3 the assisted living and memory care facilities with executive director (ED)-B and clinical nurse supervisor (CNS)-A, ED-B stated residents were offered three meals daily, per their contract; however, could "opt out" of the meal plan if they desired, and they would receive a refund of $200. ED-B stated, "It's all or nothing right now," stating there was not an option for a resident to opt out of just one meal or two meals, because it was included in the monthly cost whether they chose to eat all three meals or not, and stated, "We're just all-inclusive." The Residency Agreement, page 3 of 23, section 6, titled Meal Plan, indicated the licensee offered a meal plan described in "Attachment C" that was included in the monthly base fee "by default," and indicated "You are not required to select or pay for the meal plan to live at the Community." The agreement gave the opportunity to opt out of the meal plan at any time and noted the resident would receive a corresponding credit against the monthly base fee, and directed the resident could sign and date "Attachment C." On page 20 of 23, a document titled "Attachment C Meal Plan Selection Form," indicated the licensee provided a meal plan with three nutritious meals and snacks available seven days per week, and noted in italics, "Please check below if you wish to opt out of the Community's meal plan. If you opt out of the meal plan, you will receive a corresponding reduction in monthly fees in the amount of $[blank] per month." The next line included a box with "No Meal Plan. I do not wish to participate in the meal plan offered by the Community at this time," to be checked by the resident if they were opting out of all meals. On May 15, 2023, at 2:40 p.m., the surveyor observed a menu in a clear plastic holder on a	0 485		

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0 485	Continued From page 4 table in the assisted living and memory care buildings, titled Week At A Glance, Week 4, which included Sunday through Saturday menus for breakfast, lunch, and supper, for the current week. On May 16, 2023, at 3:10 p.m., an unidentified kitchen staff in the assisted living building stated the memory care and assisted living menus were different and she did not have a copy of the memory care menu, but directed the surveyor to the memory care building for that menu. When the surveyor requested a copy of the following week menu in the memory care building, dining services (DS)-O stated she did not have access to the menus because only the food services director (FSD)-P had access, and she was not available at this time. DS-O stated residents and their families only had access to current menus that were posted, "not one [week] before or after." On May 16, 2023, at 3:48 p.m., FSD-P provided the five-week cycle of menus for the assisted living and memory care buildings, and stated she wasn't aware that menus should be made available to all residents at least one week in advance and would be changing their process. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.	0 510		

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0 510	Continued From page 5 (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for two of three employees (unlicensed personnel (ULP)-Q and ULP-F) observed while providing cares. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On May 17, 2023, at 7:37 a.m., the surveyor observed ULP-Q provide a blood glucose check on R2 in her apartment. ULP-Q, with gloved hands, wiped the resident's finger with an alcohol wipe and then a tissue, poked R2's finger with a lancet, and placed a blood sample on the test strip. ULP-Q then removed the glove on the right hand, opened the door with the right hand, went to the medication cart outside R2's room, and	0 510		

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0 510	Continued From page 6 disposed the lancet in the sharps container. ULP-Q then removed the other glove on the left hand, and performed hand hygiene with sanitizer. On May 17, 2023, at 8:00 a.m., ULP-Q conrimed having training to perform hand hygiene after disposing of the sharps, and stated since the sharps container was attached to the med cart, it was not possible to take the container into the resident's rooms. On May 17, 2023, at 8:25 a.m., the surveyor observed ULP-F provide morning cares to R1 in her apartment. ULP-F assisted R1 to walk to the bathroom and sit on the toilet. With gloved hands, ULP-F assisted R1 to stand, and ULP-F provided perineal care to the back side of R1. ULP-F then moved to provide perineal cares in the front with the same gloves, and wiped from back to front multiple times. At this time, ULP-F adjusted R1's shirt and tag inside the back of the shirt, and then removed the gloves. Without performing hand hygiene, ULP-F placed the call pendant around R1's neck, put her glasses on her, brought the walker to R1, put the brakes on, and washed hands at the sink. On May 17, 2023, at 8:40 a.m., ULP-F acknowledged not wiping the back side first when performing perineal cares, and then moved to the front, going from back to front. ULP-F stated did not perform hand hygiene after removing gloves, and should have. On May 18, 2023, at 2:02 p.m., registered nurse (RN)-L stated hand hygiene should be performed before and after glove use, and after performing a glucometer check. In addition, RN-L stated perineal cares should be performed from front to back, and hand hygiene should be completed	0 510		

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0 510	Continued From page 7 after removing the gloves, before touching any other surfaces. The licensee's Standard Precautions policy dated revised August 2022 noted hands should be washed after removing gloves and after any direct contact with body secretions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.	0 680		

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0 680	Continued From page 8 (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to post an emergency preparedness plan prominently and failed to provide building emergency exit diagrams to all residents. This had the potential to affect all residents receiving services under the assisted living with dementia care license, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On May 15, 2023, at 11:26 a.m., the surveyors conducted a facility tour of the assisted living building and the memory care building, separated by a residential road, with executive director (ED)-B and clinical nurse supervisor (CNS)-A. Each building consisted of two levels, with residents residing on each level. There was no evidence of signage posted or information regarding the licensee's emergency preparedness plan. On May 17, 2023, at 10:53 a.m., ED-B stated the emergency preparedness plan was not posted for "general access." ED-B stated an emergency flip	0 680		

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0 680	Continued From page 9 chart was available behind the receptionist's desk in the building entrance area on the first level of the assisted living building, behind the telephone, for staff use in an emergency, but was not available in public areas or posted prominently, as required. ED-B stated the emergency preparedness plan was kept in her office; however, staff did not have access to her office when she wasn't in the building. ED-B stated she lived very close to the facility and would be able to respond quickly in an emergency to provide the emergency preparedness plan. On May 18, 2023, at 11:41 a.m., ED-B stated residents in the assisted living building were provided emergency exit diagrams upon admission; however, residents in the memory care building were not provided the emergency exit diagrams. ED-B stated she worried that providing the emergency exit diagrams may increase the potential for residents to exit seek. The licensee's Emergency Preparedness policy, undated, indicated the emergency preparedness plan would include all required elements of Appendix Z (Centers for Medicare & Medicaid Services State Operations Manual) Emergency Preparedness for All Provider and Certified Supplier Types, and would be reviewed annually. The policy lacked direction to post an emergency disaster plan prominently and to provide building emergency exit diagrams to all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 810	Continued From page 10	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the	0 810		

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0 810	Continued From page 11 licensee failed to provide the required documentation of employee and resident training on fire safety and evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on May 17, 2023, at approximately 12:10 p.m. with Director of Maintenance (DM)-C and Executive Director (ED)-B on the fire safety and evacuation training, and evacuation drills for the facility. Fire safety and evacuation plans were in ED-B office and not readily available in the memory care and assisted living buildings. Record review did not show that the licensee provided employee training on the fire safety and evacuation plan twice per year and upon hire. During interview, DM-C stated that the licensee policy is to train employees on fire safety and evacuation upon initial hire and twice per year but did not document as such. DM-C and ED-B verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure background studies were conducted prior to staff providing services, for one of four employees (unlicensed personnel)-F). In addition, the licensee failed to ensure a background study was affiliated with the assisted living license for one of four employees (ULP-G). 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 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).	01290		

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01290	Continued From page 13 This practice resulted in an immediate correction order on May 19, 2023. The findings include: ULP-F had a hire date of March 13, 2023. ULP-F's employee record lacked evidence the licensee had a background study clearance for ULP-F. The licensee's staff schedule indicated ULP-F was scheduled to work on May 15, 2023, from 6:15 a.m. to 2:30 p.m., May 17, 2023, from 6:15 a.m. to 2:30 p.m., May 18, 2023, from 6:15 a.m. to 2:30 p.m., and May 19, 2023, from 6:15 a.m. to 2:30 p.m. On May 16, 2023, at 8:25 a.m., the surveyor observed ULP-F provide morning cares for resident (R1) in bedroom, assisted R1 to the bathroom, provide perineal cares, and clean clothes for the day. On May 19, 2023, at 8:30 a.m., ULP-F was observed in the hallway of the assisted living building with the computer on the stand. During an interview on May 19, 2023, at 10:25 a.m., executive director (ED)-B stated she talked to business office director (BOM)-N and was told that ULP-F did not complete the fingerprinting portion of background study submission, therefore, the licensee did not have a background clearance letter. ED-B stated BOM-N told her that she talked to ULP-F who stated they never received an email directing to complete the fingerprinting portion. ED-B stated although ULP-F had not completed fingerprinting, ULP-F had been working with residents in the facility,	01290		

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01290	Continued From page 14 and was here in the building at this time. ED-B stated the background study process was broken and difficult to navigate to get the clearance completed. ULP-G was hired on January 7, 2020, under the comprehensive license, and began providing assisted living services on August 1, 2021. On May 17, 2023, at 7:04 a.m., ULP-G was observed while preparing and administering eye drops and oral medications to R9. ULP-G's record lacked documentation of a background study affiliated with the facility's license. On May 19, 2023, at 12:42 p.m., regional nurse director (RND)-D stated ULP-G's background study was not affiliated with the facility's license. The licensee's Abuse Prevention, Intervention, Reporting and Investigation policy, dated February 2023, indicated prior to a new employee starting a work schedule, the licensee would obtain a criminal background check. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	01290		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	01620		

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01620	Continued From page 15 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) assessed two of two residents (R1, R5) with falls, for causative factors to determine individualized interventions to reduce the resident's risk for injury, and failed to ensure the RN completed a comprehensive reassessment no more than 90 days after the last assessment for four of five residents (R1, R2, R3, R4), and failed to reassess one of one resident (R8) who attempted to elope.	01620		

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01620	Continued From page 16 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ASSESSMENTS WITH FALLS AND 90 DAY ASSESSMENTS R1 R1's diagnoses included supraventricular tachycardia, legal blindness, and chronic cough. R1's record contained an Assessment As of Date dated August 30, 2022, and December 22, 2022 (114 days after the last assessment). R1's Assessment As Of Date dated March 22, 2023, noted R1 was independent with bed mobility and transferring, and utilized a bed rail and walker. R1's Individualized Abuse Prevention Plan dated March 22, 2023, noted the resident was at risk to self abuse related to being a high fall risk, and instructed staff to assist per her plan of care, anticipate needs, and ensure they are met. R1's Service Plan dated effective April 5, 2023, noted services including assistance with morning cares, medication administration, and incontinent care. On May 17, 2023, at 7:00 a.m., the surveyor	01620		

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01620	Continued From page 17 observed unlicensed personnel (ULP)-E administer medications to R1 in her room. R1 sat from a lying position, and once seated at the edge of the bed, held the bedrail in the right side of the bed. In addition, at 8:25 a.m., the surveyor observed R1 ambulate with a walker and the assistance of ULP-F from the bed to the bathroom. R1's Incident Reports and Resident Notes revealed R1 had multiple falls as noted below. - December 26, 2022, at 4:45 p.m., R1 slid out of bed., and at 8:30 p.m. R1 fell in the kitchen. A resident note dated January 13, 2023, for the events on December 26, 2022, noted a review of the incidents and the resident's vital signs and diagnoses. However, it noted no new interventions; - January 7, 2023, at 8:00 p.m., R1 slid out of bed. A resident note dated January 7, 2023, noted a review of the incident and the resident's vital signs and diagnoses. However, it noted no new interventions; - February 12, 2023, at 5:00 a.m., R1 was found on her back in the bathroom. A resident note dated February 12, 2023, noted a review of the incident and the resident's vital signs and diagnoses. However, it noted no new interventions; - March 24, 2023, at 1:30 p.m., R1 fell in the elevator while trying to sit of her walker. A resident note dated March 27, 2023, noted a review of the incident and the resident's vital signs and diagnoses. However, it noted no new interventions; and - April 7, 2023, at 5:55 a.m., R1 fell in her bedroom transferring from her bed to the walker. A resident note dated April 10, 2023, noted a review of the incident and the resident's vital signs and diagnoses. However, it noted no new	01620		

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01620	Continued From page 18 interventions. On May 18, 2023, at 2:48 p.m., clinical nurse supervisor (CNS)-A stated they are working on getting a new bed and wheelchair for R1, and an order had been received for physical and occupational therapy evaluation. CNS-A stated no new interventions had been included on the nursing notes, and stated they had been using a new program for the incidents and were still working out issues with the program. R2 R2's diagnoses included ventricular fibrillation, macular degeneration, and diabetes mellitus type II. R2's record contained an Assessment As Of Date dated August 18, 2022, and November 29, 2022 (103 days after the last assessment). R2's Service Plan dated effective January 25, 2023, noted services including medication administration and assistance with morning cares and dressing. R5 R5's diagnoses included Parkinson's Disease, dementia, history of stroke, atrial fibrillation (irregular and often very rapid heart rhythm), orthostatic hypotension (sudden drop in blood pressure upon standing from sitting or lying position) and frequent falls. R5's Service Plan (Private) - Addendum to Contract, dated January 25, 2023, indicated R5's services included assistance with dressing, hygiene, ambulation/exercise, compression	01620		

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01620	Continued From page 19 stockings, behavior monitoring, escort, incontinence care, and medication administration. R5's Assessment As Of Date, dated March 15, 2023, indicated R5's needed assistance for activities of living and may not call for help related to dementia, therefore, staff were directed to complete every 1/2 hour safety checks and anticipate needs. Also included, R5 was a "high fall risk," and needed assistance when getting in and out of bed and one staff assisted with transfers, using a gait belt for safety, ensuring steadiness prior to resident ambulating. R5's Individualized Abuse Prevention Plan, dated March 15, 2023, indicated R5 was at risk to self abuse related to high fall risk and self neglect, and inappropriately transferring related to dementia. Staff were directed to anticipate and ensure needs were met, and complete every 30 minute safety checks. On May 15, 2023, at 3:43 p.m., the surveyor observed as ULP-T entered R5's room, calling her name, and went into R5's bathroom to find her standing at her sink. ULP-T stated she had just assisted R5 with toileting and left the room momentarily to empty R5's trash. ULP-T assisted R5 to sit back in the wheelchair, and stated, "I can't leave you for a minute," to which R5 smiled and stated, "I can do it myself." R5's Incident Reports and Resident Notes revealed R5 had multiple falls as noted below. - April 1, 2023, at 8:00 a.m., R5 was found on the floor in her bedroom and reported she was trying to walk over to the call light and she tripped. Resident Note dated April 3, 2023, indicated a review of the incident and vital signs, and noted POA and PCP were notified. Also indicated,	01620		

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01620	Continued From page 20 "Actions taken; will complete focused assessment and upgrade the plan of care as appropriate," however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the resident's risk for injury. - April 3, 2023, at 7:00 a.m., R5 was found on the floor near her bathroom and stated she was reaching for a cap to her lotion and fell over. Resident Note dated April 3, 2023, indicated a review of the incident and vital signs, and noted primary care provider PCP was notified. Also indicated, "Actions taken; will complete focused assessment and upgrade the plan of care as appropriate;" however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the resident's risk for injury. - April 7, 2023, at 7:00 p.m., R5 was found on the floor in her apartment and reported she was trying to walk to her table from her couch and lost her balance. Resident Note dated April 10, 2023, by LPN, noted a review of the incident with no injuries or head strikes, vital signs stable, and POA and PCP notified. Resident Note dated April 12, 2023, indicated a review of the incident and vital signs, "Actions taken; will complete focused assessment and upgrade the plan of care as appropriate;" however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the resident's risk for injury. - April 10, 2023, at 4:15 p.m., R5 was sitting on the couch, eating pudding, and tried to grab something off the floor and fell onto the floor. R5 reported pain in right forearm and elbow and anterior/posterior hip and indicated PCP was notified. Incident Report noted a comprehensive assessment was completed and root cause analysis was "balance instability," with	01620		

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01620	Continued From page 21 interventions to remind resident to use assistive device and staff for assistance with items dropped on the floor, keep assistive device within reach, and staff to anticipate needs during safety checks. Resident note dated April 11, 2023, indicated a review of the incident and vital signs, and indicated "Actions taken; will complete focused assessment and upgrade the plan of care as appropriate." R5's record lacked evidence that a comprehensive assessment was completed. - April 11, 2023, at 6:45 a.m., R5 was found on the floor near her bathroom door. R5 reported she was trying to clean up her apartment and fell, and reported pain in her right shoulder. Incident Report noted a comprehensive assessment was completed and root cause analysis was self-transferring and balance instability, with interventions to remind resident to use assistive device and staff for assistance with items dropped on the floor, keep assistive device within reach, and staff to anticipate needs during safety checks. PCP was notified. Resident note dated April 11, 2023, indicated a review of the incident and vital signs, and indicated, "Actions taken; will complete focused assessment and upgrade the plan of care as appropriate." R5's record lacked evidence that a comprehensive assessment was completed. -April 13, 2023, at 12:00 p.m., R5 was found on the floor in her bedroom by her bed and had a pair of jeans under her head. Resident Note dated April 14, 2023, indicated a review of the incident and vital signs, and noted POA and PCP were notified. Also indicated, "Actions Taken...Will complete focused assessment and upgrade the plan of care as appropriate;" however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the	01620		

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01620	Continued From page 22 resident's risk for injury. - April 17, 2023, at 5:00 p.m., R5 was found on the floor, sitting against the couch. R5 reported she was going to walk over to the call chord and "slipped" off her couch, and stated she had pain in her back. Resident note dated April 21, 2023, indicated a review of the incident and vital signs, PCP was notified. Also indicated, "Actions taken; will complete focused assessment and upgrade the plan of care as appropriate;" however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the resident's risk for injury. - April 18, 2023, at 8:30 p.m., R5 was found face down in the doorway to her apartment and reported she wanted to know who was out on the floor. Incident Report noted nurse was not notified. Resident note dated April 21, 2023, indicated a review of the incident and vital signs, and lacked evidence the PCP was notified. Also indicated, "Actions taken; will complete focused assessment and upgrade the plan of care as appropriate;" however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the resident's risk for injury. - April 19, 2023, at 4:50 p.m., R5 was found on the floor lying on her side, and reported she was trying to get something "over there." Resident note dated April 21, 2023, indicated a review of the incident and vital signs, and lacked evidence the PCP was notified. Also indicated, "Actions taken; will complete focused assessment and upgrade the plan of care as appropriate;" however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the resident's risk for injury. - April 21, 2023, at 7:00 a.m., R5 was found on	01620		

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01620	Continued From page 23 the floor in front of her recliner, and reported she was looking for an iron to iron her clothes and fell. Resident Note dated April 24, 2023, indicated a review of the incident and vital signs, and noted POA and PCP were notified. Also noted, "Resident has falls nearly daily. All fall protocols are in place. Discussion made with guardian and daughter for potential additional interventions." Further, "Actions taken; will complete focused assessment and upgrade the plan of care as appropriate;" however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the resident's risk for injury. - April 21, 2023, at 7:50 a.m., R5 was found by housekeeping staff, on the floor in her apartment. Resident note dated April 21, 2023, indicated a review of the incident and vital signs, and noted a meeting with R5's guardian was scheduled. Also indicated, "Actions taken; will complete focused assessment and upgrade the plan of care as appropriate;" however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the resident's risk for injury. - April 24, 2023, at 7:30 a.m., R5 was found on the floor beside her bed, and reported she was trying to look for rabbits and coins under her bed. Resident note dated April 24, 2023, indicated a review of the incident and vitals signs and noted R5 had a sore neck and lower back. Also noted, "Resident has falls nearly daily. All fall protocols are in place. Discussion made with guardian and daughter for potential additional interventions." Further, "Actions taken; will complete focused assessment and upgrade the plan of care as appropriate;" however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the resident's risk for injury. On April	01620		

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	26585	A. BUILDING: _____ B. WING _____	05/22/2023

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01620	Continued From page 24 25, 2023, an order was received for physical therapy (PT) to evaluate and treat. - April 25, 2023, at 3:00 p.m., R5 fell while attempting to use the restroom. Resident note dated April 26, 2023, indicated a review of the incident, vital signs, PCP was notified, and noted PT had been ordered for evaluation for strengthening. Also included, "Actions taken; will complete focused assessment and upgrade the plan of care as appropriate;" however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the resident's risk for injury. - April 28, 2023, at 8:00 a.m., R5 fell while getting up from her wheelchair without calling for assistance and sustained an abrasion on her left knee. Resident Note dated May 2, 2023, indicated a review of the incident, PCP was notified, and indicated, "Actions taken will complete focused assessment and upgrade the plan of care as appropriate;" however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the resident's risk for injury. - May 4, 2023, at 3:00 p.m., R5 fell while transferring herself. Resident note dated May 8, 2023, indicated a review of the incident, vital signs, guardian and PCP were notified, and indicated, "Resident has frequent falls, suspecting behavior but unsure, PT consult was requested." Also noted, "Actions taken; will complete focused assessment and upgrade the plan of care as appropriate;" however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the resident's risk for injury. - May 6, 2023, at 2:40 a.m., R5 was found sitting	01620		

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01620	Continued From page 25 on her bottom, next to her bed, and reported she was trying to get to the bathroom. Resident note dated May 8, 2023, indicated a review of the incident, vital signs, guardian and PCP were notified, and noted, "Actions taken; will complete focused assessment and upgrade the plan of care as appropriate;" however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the resident's risk for injury. - May 6, 2023, at 1:30 p.m., R5 fell in the dining room while self transferring from the dining chair to her wheelchair. Resident note dated May 8, 2023, indicated a review of the incident, vital signs, guardian and PCP were notified, and noted, "Resident has frequent falls, suspecting behavior but unsure, PT consult was requested." Also included, "Actions taken; will complete focused assessment and upgrade the plan of care as appropriate;" however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the resident's risk for injury. - May 9, 2023, at 5:00 p.m., R5 fell off the couch while attempting to find her glasses. Resident Note dated May 10, 2023, indicated a review of the incident, vital signs, guardian and PCP were notified, and noted, ""Actions taken; will complete focused assessment and upgrade the plan of care as appropriate;" however, lacked evidence the RN completed an assessment to assess causative factors to determine individualized interventions to reduce the resident's risk for injury. On May 18, 2023, at 2:48 p.m., CNS-A stated no new interventions had been included on the nursing notes, and stated they had been using a	01620		

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01620	Continued From page 26 new program for the incidents and were still working out issues with the program. On May 19, 2023, at 9:01 a.m., registered nurse (RN)-H stated a reassessment had not been completed for R5 since March 15, 2023, and stated she should have been reassessed due to continued multiple falls, to assess causative factors and to determine interventions to reduce the risk for injury. R3 R3's diagnoses included symptoms and signs involving cognitive functions and awareness, and psychosis (loss of contact with reality). R3's Service Plan (Waiver) - Addendum to Contract, dated January 25, 2023, indicated R3 received services including assistance with dressing, hygiene, compression stockings, behavior monitoring and management, catheter care, escort, peri care, and medication management. R3's record included an Assessment As Of Date dated September 26, 2022, December 30, 2022 (95 days after the last assessment), and April 5, 2023 (96 days after the last assessment). R4 R4's diagnoses included Alzheimer's Disease, anxiety, type 2 diabetes, chronic obstructive pulmonary disease, dementia, schizoaffective disorder (psychosis with mood symptoms), altered mental status, and personality disorder. R4's Service Plan (Waiver) - Addendum to Contract, dated January 25, 2023, indicated R4 received services including dressing, hygiene, showering, compression stockings, behavior	01620		

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01620	Continued From page 27 monitoring, monthly vital sign monitoring, daily weights, assistance with toileting and peri care, safety checks, escorts, transfer assistance, and medication administration. R4's record included an Assessment As of Date dated November 7, 2022, and February 13, 2023 (98 days after the last assessment). On May 18, 2023, at 2:12 p.m., CNS-A stated the licensee had been short nurses for some time and the assessments were behind schedule. ELOPEMENT ATTEMPT R8 R8's diagnoses included Alzheimer Dementia. R8's Service Plan (Waiver) - Addendum to Contract, dated January 5, 2022, indicated R8 received assistance with dressing, hygiene, daily room order, fluid encouragement, monthly vital sign monitoring, behavior monitoring, showering, medication management and administration, and twice daily safety checks. R8's Assessment As of Date, dated May 2, 2023, indicated R8 had decreased cognition related to dementia and resided in the Memory Care secured facility, ambulated independently with use of a cane, high fall risk, and was at risk for elopement with note directing "1/2 hour safety checks." On May 15, 2023, at 2:52 p.m., two unidentified females stopped the surveyor in the common area near the entrance of the secured memory care facility, and stated R8 was outside. The surveyor observed R8 outside, walking away from the building, and summoned a staff member that was walking outside. Just then, activities (A)-I	01620		

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01620	Continued From page 28 came out of the building and brought R8 back inside. While the door was open, R10 walked outside and was quickly brought back in by A-I. On May 18, 2023, at 1:06 p.m., A-I stated if R8 was by an open door, he would go out, and stated, "I don't think he's trying to get out knowingly, it's not a thing that happens often, but it happens, it's a concern." A-I stated, in the past, there was a receptionist in the Memory Care facility, near the entrance, and there are two offices near the entrance, but the offices were not always occupied, and the doors were usually closed. A-I stated there was a sign on the entrance door to the Memory Care facility in the past, encouraging visitors to be cautious when opening the door to ensure residents' safety, but stated other signs have replaced it. A-I stated she reported the incident to care staff and the medication passer when she brought R8 and R10 back to their pod. On May 18, 2023, at 4:06 p.m., RN-M stated R8's incident was reported to her on May 16, 2023, by care staff. RN-M stated she "re-coached staff to be more cognizant of exits," especially for residents that resided in the B-pod, and stated she was not aware that R10 had also walked out the door while A-I was bringing R8 inside. RN-M stated she had not reassessed R8 upon being made aware of the incident. Review of R8's Resident Notes - One Resident, dated May 5, 2023, through May 18, 2023, lacked documentation regarding the incident. On May 18, 2023, at 4:13 p.m., CNS-A stated an incident report should have been completed and R8 should have been reassessed when RN-M became aware of R8's attempt to leave the	01620		

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01620	Continued From page 29 facility. The licensee's Elopement Risk Prevention/Missing Resident policy, dated February 2023, indicated an elopement risk evaluation was completed on all residents upon admission, annually, and with any significant change in condition. The policy directed interventions when responding to an actual elopement, which included the family and physician would be notified of the incident, and notification would be documented in the resident's record. Also included, an investigation would be conducted and root cause of the elopement would be determined, with the resident's Service Plan/Care Plan being updated if needed. Further, the policy directed to document in the resident record all elopement attempts and events and to complete an Incident Report within 24 hours. The licensee's undated Assessments, Review & Monitoring policy noted ongoing resident reassessments must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. The licensee's Fall Potential policy dated February 2023 noted staff would evaluate each resident after any fall. It noted after any resident fall, staff will review specific care coordination needs and seek to prevent recurrence. The licensee's Incident Management policy, dated February 2023, indicated all incidents or adverse events occurring in the community or on community property must be reported immediately and investigated to assure appropriate actions are taken to prevent reoccurrence and/or reduce the risk of injury.	01620		

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01620	Continued From page 30 Also included, an investigation should be completed by designated supervisory staff within 24 hours or next business day, depending on the severity of the incident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01700 SS=E	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of	01700		

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01700	Continued From page 31 medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment to determine what medication management services would be provided and how the services would be provided, for two of two residents (R4, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on May 15, 2023, at 10:04 a.m., executive director (ED)-B and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the residents at the facility. R4 R4's record lacked evidence the RN had conducted a medication assessment to include observation of R4's ability to self-administer a prescribed nebulizer, once set up. R4's diagnoses included Alzheimer's Disease, heart failure, anxiety, type 2 diabetes, chronic obstructive pulmonary disease, dementia,	01700		

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01700	Continued From page 32 schizoaffective disorder (psychosis with mood symptoms), altered mental status, and personality disorder. R4's Service Plan (Waiver) - Addendum to Contract, dated January 25, 2023, indicated R4 received services including dressing, hygiene, showering, compression stockings, behavior monitoring, monthly vital sign monitoring, daily weights, assistance with toileting and peri care, safety checks, escorts, transfer assistance, and medication administration. On May 15, 2023, at 3:16 p.m., the surveyor knocked and entered R4's apartment with her permission. R4 was sitting in her recliner with the back of the chair reclined and the footrest in the elevated position. R4 was observed to be holding her nebulizer machine with attached tubing on her chest with her left hand, and holding the attached nebulizer mouthpiece upside-down, in her right hand. The nebulizer was not on. When the surveyor asked if she had been administering her nebulizer, R4 stated she was "trying to figure it out," and stated, "I can't figure it out." When the surveyor asked R4 if the staff had just brought her medication in, R4 stated, "No, they bring my medicine if I tell them." R4's prescriber orders, dated April 3, 2023, included "DuoNeb [relaxes and opens air passages to make breathing easier] - 1 [one] Neb [nebulizer] INH [inhaled] BID [twice daily] and BID PRN [as needed]." On May 15, 2023, at 3:26 p.m., unlicensed personnel (ULP)-S stated R4 liked to watch television in her room, liked activities, had a good appetite, needed help to get ready for bed, and was a "night owl" and liked to stay up late. ULP-S	01700		

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01700	Continued From page 33 stated R4 received a nebulizer treatment at 7:00 p.m., which she would set up and hand to her, and go back into R4's room when it was completed. ULP-S stated, "She can do it on her own. We turn it off when it's done and have her rinse her mouth." R4's Med (medication) Admin (administration) Summary (MAR), dated May 2023, listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given. R4's MAR included the following: - "Iprat-Albu [ipratropium and albuterol] [same as DuoNeb] Neb (Daily) 0.5-3(2.5) mg [milligrams]/3 Nebulize 1 vial twice daily. **Administer 1 VIAL into neb cup/attached to tubing and machine.** Rinse resident's mouth out after completing neb treatment. RINSE OUT NEB CUP AFTER EACH USE-PLACE ON PAPER TOWEL TO DRY." The MAR indicated the nebulizer was scheduled for administration at 7:00 a.m. and 7:00 p.m.; however, documentation on May 15, 2023, at 7:00 a.m., May 15, 2023, at 7:00 p.m., May 16, 2023, at 7:00 a.m., May 16, 2023, at 7:00 p.m., and May 17, 2023, at 7:00 a.m., indicated the Iprat-Albu Neb was not given due to not being available. On May 18, 2023, at 4:23 p.m., registered nurse (RN)-M stated she had never been notified by staff administering medications that R4 was using the nebulizer machine inappropriately; however, stated she had not observed R4 when completing the medication management assessment and while R4 self-administered the nebulizer, to ensure R4 was capable of administering the nebulizer without staff present.	01700		

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01700	Continued From page 34 R2 R2's record lacked evidence the RN had conducted a medication assessment to include observation of R2's ability to self-administer a prescribed nebulizer, once set up. R2's diagnoses included ventricular fibrillation, macular degeneration, and diabetes mellitus type II. R2's signed prescriber orders dated January 18, 2023, included a sheet completed by CNS-A which asked "Do you believe the individual is capable of administering his/her own medication?" and was marked as no. In addition, the orders included DuoNeb (Ipratropium-Albuterol) 0.5 mg/2.5 mg/3 mL inhalation two times daily for cough. R2's Service Plan dated effective January 25, 2023, noted services including medication administration. R2's Med Admin Summary dated May 2023 listed medications as prescribed, times to be administered, and staff initials on each date to indicate the medications had been given. R2's MAR included the following: "Duo Neb (Ipratropium-Albuterol) 0.5 mg/2.5 mg/3 mL (Daily) Administer 1 duo neb cartridge twice daily." The MAR indicated the nebulizer was scheduled for administration at 7:00 a.m. and 7:00 p.m. On May 17, 2023, at 7:40 a.m., the surveyor entered R2's apartment with ULP-Q, with R2's permission, and observed ULP-Q provide R2 with her morning medications, including her DuoNeb	01700		

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01700	Continued From page 35 nebulizer treatment. ULP-Q stated the device had to be emptied and rinsed as there was medication remaining from the night before. At this time, R2 stated she had fallen asleep last night and didn't take the medication. After exiting the resident's room, ULP-Q stated typically the ULP's set up the nebulizer for R2 and leaves her to administer it independently. ULP-Q stated if they had to wait with the nebulizer in the room they would fall behind with the medication pass. ULP-Q stated they go back to check that the medication had been administered after approximately 10 minutes. On May 18, 2023, at 2:02 p.m., RN-L stated if the resident was able to verbalize the action, she would be ok to independently administer the nebulizer. At this time, CNS-A stated there should be an assessment if the resident is doing it on their own, and they don't assess if the staff are setting it up and putting it on. CNS-A stated the assessment should include if they are able to start and stop the machine on their own. The licensee's Medication Management policy, undated, indicated, prior to providing medication management services, the RN must conduct a face-to face assessment with the resident to determine what medication management services would be provided and how the services would be provided, and would monitor and reassess the resident's medication management services as needed when the resident presented with symptoms or other issues that may be medication-related and, at a minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

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01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment for one of one resident (R8) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on May 15, 2023, at 10:04 a.m., executive director (ED)-B and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the residents at the facility. R8's diagnoses included Alzheimer Dementia. R8's Service Plan (Waiver) - Addendum to Contract, dated January 5, 2022, indicated R8	01710		

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01710	Continued From page 37 received medication management services which included medication administration twice daily. R8's prescriber orders, dated February 28, 2023, included the following: - nystatin powder (antifungal) topically to affected area twice daily. R8's prescriber orders, dated May 5, 2023, included the following: - Voltaren Gel (pain reliever) to affected areas once daily and as needed. On May 16, 2023, at 11:48 a.m., the surveyor observed while unlicensed personnel (ULP)-R administered scheduled medications for various residents. While standing at the medication cart, a female approached ULP-R, asking for "the powder." ULP-R reached into the medication cart and pulled out a large clear plastic ziplock type bag and handed it to the female. ULP-R identified the female as R8's daughter and stated R8 had been refusing to allow staff to apply the nystatin powder and Voltaren Gel, so when his daughters were visiting, they applied them. R8's Individualized Medication Management Plan (IMMP), dated May 2, 2023, indicated R8 needed help with medication administration and all medications were to be administered by the licensee's med (medication) passers per provider order and registered nurse (RN) delegation. The plan indicated the med passer was to monitor R8 until all medications were administered and no medications were to be left with the resident or at bedside. The plan noted R8 had occasional resistance to taking medications, and directed staff to document refusals and missed doses and to notify RN of any medications declined or missed.	01710		

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01710	Continued From page 38 R8's Med Admin (administration) Summary, dated May 2023, indicated the following: - On May 1, 2023, at 7:00 a.m., documentation indicated nystatin powder was "Done by daughter;" - On May 3, 2023, at 7:00 a.m., nystatin powder was applied by daughter whom was visiting; - On May 3, 2023, at 3:00 p.m., R8 refused nystatin powder; - On May 4, 2023, at 7:00 a.m., R8 refused nystatin powder; - On May 4, 2023, at 3:00 p.m., R8 refused nystatin powder; - On May 5, 2023, at 7:00 a.m., family administered nystatin powder; - On May 7, 2023, at 7:00 a.m., R8 refused nystatin powder; - On May 7, 2023, at 3:00 p.m., nystatin powder applied by daughter; - On May 9, 2023, at 7:00 a.m., nystatin powder applied by daughter; - On May 11, 2023, at 7:00 a.m., daughter stated she would apply Voltaren Gel when she arrived at the facility; - On May 14, 2023, at 7:00 a.m., Voltaren Gel was administered by daughters; and - On May 15, 2023, at 7:00 a.m., nystatin powder was applied by daughter. R8's record lacked evidence of monitoring and reassessment of the resident's medication management services when R8 was refusing to allow staff to administer the nystatin powder and the Voltaren Gel. On May 18, 2023, at 4:19 p.m., RN-H stated R8's daughters wanted to be involved in his care, and because R8 often refused to allow staff to apply the nystatin powder and the Voltaren Gel, R8's	01710		

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01710	Continued From page 39 daughters stated they would apply them when they visited R8. RN-H stated, although he was aware of the above, R8's medication reassessment did not include the above noted content and the daughters had not been observed while applying the prescribed topical medications to ensure the administration was conducted as prescribed. The licensee's Medication Management policy, dated January 2022, indicated a RN must conduct a face to face nursing assessment of the resident's need for medication management services, and each resident would be monitored and reassessed as needed when the resident presented with symptoms or other issues that may be medication-related, and, at minimum, annually. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01760 SS=E	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not	01760		

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01760	Continued From page 40 administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for three of eight residents (R1, R3, R4), and failed to verify accuracy of prescriber orders when transcribing orders for one of eight residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: MEDICATIONS ADMINISTERED AS PRESCRIBED R1 R1's diagnoses included supraventricular tachycardia, legal blindness, and chronic cough. R1's prescriber orders dated February 23, 2023, included Flovent HFA 44 micrograms (mcg) inhaled one puff twice daily for chronic cough. R1's Service Plan dated effective April 5, 2023, noted services including assistance with morning cares, medication administration, and incontinent care.	01760		

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01760	Continued From page 41 On May 17, 2023, at 7:00 a.m., the surveyor observed unlicensed personnel (ULP)-E administer R1's Flovent inhaler. ULP-E then prompted R1 to drink some water, "so you don't get thrush", which R1 did, and swallowed the water. After exiting R1's room, ULP-E stated as not being sure if the medication was a steroid, so residents are encouraged to rinse after all inhaler use. When the surveyor looked up the medication and the manufacturer's instructions to rinse and spit out the water, ULP-E stated the practice would be to go back in and ask R1 to rinse and spit, and would ask the nurse to add the instructions the the administration record for staff to see. On May 18, 2023, at 2:02 p.m., registered nurse (RN)-L stated it is expected that a resident rinse and spit out the water after use of the Flovent inhaler. The manufacturer's instructions for use dated revised August 2021 noted "Rinse your mouth with water without swallowing after each dose of FLOVENT HFA. This will help lessen the chance of getting a yeast infection (thrush) in your mouth and throat. R3 R3's diagnoses included symptoms and signs involving cognitive functions and awareness, and psychosis (loss of contact with reality). R3's Service Plan (Waiver) - Addendum to Contract, dated January 25, 2023, indicated R3 received services including assistance with dressing, hygiene, compression stockings, behavior monitoring and management, catheter care, escort, peri care, and medication	01760		

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01760	Continued From page 42 management. R3's Assessment As Of Date, dated May 6, 2023, indicated all medications were to be administered to R3 by licensee's medication passers per provider order and RN delegation, and noted medications were to be monitored by medication passer and licensed nurse (LN). Also included, "LN to reorder medications as needed. Most Medications [sic] on cycle fill and automatically refilled every month." On May 17, 2023, at 8:24 a.m., the surveyor observed ULP-G attempt to convince R3 to return to his apartment from the dining room in order to could administer his medication; however, R3 refused. R3's prescriber orders, dated January 13, 2023, included calcium carbonate (dietary supplement) 500 mg (milligrams) one tablet by mouth twice daily. Review of R3's Med (medication) Admin (administration) Summary, dated April 2023, and May 2023, indicated R3 was given calcium carbonate from April 1, 2023, through April 22, 2023, at 9:00 a.m., and 7:00 p.m., as ordered, documented with initials of staff administering. Documentation for calcium carbonate on April 23, 2023, through May 17, 2023, indicated a red circle around initials at 9:00 a.m., and 7:00 p.m., with notes indicating "Medication not available." On May 19, 2023, at 9:44 a.m., clinical nurse supervisor (CNS)-A stated the electronic medical record dashboard report shows when medications are missing and nursing staff should be paying attention to that.	01760		

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01760	Continued From page 43 On May 19, 2023, at 9:50 a.m., RN-M stated she had ordered R3's calcium carbonate "a couple days ago," and stated she did see it back in April but "hadn't gotten to it." RN-M stated she does look through the medication cart but stated she expected the staff to let her know when medications were missing. On May 19, 2023, at 9:52 a.m., CNS-A stated reordering R3's missing medications should have been initiated sooner than this. R4 R4's diagnoses included Alzheimer's Disease, anxiety, type 2 diabetes, chronic obstructive pulmonary disease, dementia, schizoaffective disorder (psychosis with mood symptoms), altered mental status, and personality disorder. R4's Service Plan (Waiver) - Addendum to Contract, dated January 25, 2023, indicated R4 received services including dressing, hygiene, showering, compression stockings, behavior monitoring, monthly vital sign monitoring, daily weights, assistance with toileting and peri care, safety checks, escorts, transfer assistance, and medication administration. R4's Assessment As Of Date, dated May 12, 2023, indicated the licensee managed all of R4's medications, ordering and set up. Also indicated, "Medications will be requested when there are 7 days left of medication. Staff to notify LN if med does not arrive within 2 days. Staff to notify LN daily when there are only 3 days left of medication if the medication has not arrived in the community. Staff to notify LN every administration of medication that the med is not available." On May 17, 2023, at 7:50 a.m., the surveyor	01760		

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01760	Continued From page 44 observed as ULP-G prepared to give R4 medications. ULP-G stated R4 had a nebulizer ordered to be administered at 7:00 a.m.; however, the nebulizer medication was not available. ULP-G stated, "I think the nurse knows about it." R4's prescriber orders, dated April 3, 2023, indicated DuoNeb (combination of albuterol and ipratopium) (treats narrowing of airway) one nebulizer inhaled twice daily and twice daily as needed. Review of R4's Med Admin Summary, dated May 2023, revealed R4 had not received the nebulizer on May 15, 2023, at 7:00 a.m., and 7:00 p.m., May 16, 2023, at 7:00 a.m., and 7:00 p.m., or May 17, 2023, at 7:00 a.m., with documentation indicating "Medication not available." On May 18, 2023, at 4:10 p.m., RN-M stated she was made aware on May 15, 2023, that R4's nebulizer medication was not available and needed to be reordered. The medication was ordered at that time, and was received on May 16, 2023, in the evening, although was not given until mid-morning on May 17, 2023, when it was realized that the medication had been received. RN-M stated staff should have notified her earlier so that the medication could have been ordered and R4 would not have missed doses. TRANSCRIPTION OF ORDERS R5 R5's diagnoses included Parkinson's Disease, dementia, history of stroke, atrial fibrillation (irregular and often very rapid heart rhythm), orthostatic hypotension (sudden drop in blood pressure upon standing from sitting or lying position) and frequent falls.	01760		

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01760	Continued From page 45 R5's Service Plan (Private) - Addendum to Contract, dated January 25, 2023, indicated R5's services included assistance with dressing, hygiene, ambulation/exercise, compression stockings, behavior monitoring, escort, incontinence care, and medication administration. On May 16, 2023, at 3:15 p.m., R5 was sitting in her wheelchair at her table in her apartment, and stated she was working on some business paperwork. Review of R5's Med Admin Summary, dated May 2023, indicated R5 received polyethylene glycol 3350 powder with directions to mix 17 grams (one capful) with 8 ounces of fluid and give by mouth twice daily; however, it was only listed once on the Med Admin Summary at 8:00 a.m. R5's prescriber orders, signed January 11, 2023, included "Polyethylene Glycol 3350 Powder Give; 17 grams (one capful) by mouth TWICE daily, **Mix with 8 ounces of fluid**;" however directed to give at 8:00 a.m. daily. On May 19, 2023, at 9:01 a.m., RN-H stated R5 was receiving the polyethylene glycol once daily and could not explain why the Med Admin Summary indicated to give twice daily; however, stated he would get clarification from R5's prescriber. The licensee's Medication & Supplies - Reordering policy, undated, indicated nursing staff would assist residents to make sure medications and supplies were ordered and available as needed. Also included, when a resident needed medication and/or supplies reordered from the pharmacy or supplier, staff	01760		

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01760	Continued From page 46 would contact them, and the RN or designated staff would plan ahead for the needs of residents for refills on prescriptions prior to holidays and weekends. The licensee's Medication & Treatment Record policy, undated, indicated the licensee would create and maintain a correct and accurate medication record for each resident receiving medication assistance or administration. The licensee's Metered Dose Inhaler Medication Competency dated revised October 2018 instructed staff to have resident rinse the mouth with water and spit out after the medication was administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure accurate medication prescription labels for one of eight residents (R9).	01890		

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01890	Continued From page 47 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: During the entrance conference on May 15, 2023, at 10:04 a.m., executive director (ED)-B and clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the residents at the facility. R9 R9's diagnoses included Parkinson's Disease, dementia, difficulty in walking, and constipation. R9's Service Plan, dated January 25, 2023, indicated R9 required services including dressing, hygiene, ambulation, exercise, behavior management, bowel movement tracking, daily room order, fluid encouragement, monthly vital sign monitoring, shower, safety checks three times daily, and medication management/administration. On May 17, 2023, at 7:04 a.m., the surveyor observed while unlicensed personnel (ULP)-G prepared to give R9 medications. ULP-G stood at the medication cart, outside of R9's apartment, and punched medications from punch packs into a plastic cup. ULP-G took a large plastic bottle out of the medication cart and poured the powdered contents into the bottle's cap, and stated R9 was to receive a capful of the contents,	01890		

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01890	Continued From page 48 mixed with water, every other day. When the surveyor observed the bottle, the prescription label indicated the bottle contained polyethylene glycol (treat constipation) and directed to mix 1/2 capful (8.5 grams) in liquid and drink once daily, and mix 1/2 capful (8.5 grams) in liquid and drink once daily as needed. When the surveyor questioned ULP-G about the discrepancy, ULP-G indicated noticing the label was different than the medication administration record and questioned it "in my head," but had not reported it to anyone. ULP-G called the nurse to inform her of the discrepency, however, did not receive an answer. ULP-G indicated receiving medication training three years ago by an RN whom was no longer employed at the facility. R9's Medication Review, signed January 11, 2023, included polyethylene glycol 3350 give one capful (17 grams) by mouth every other day. R9's Med (medication) Admin (administration) Summary, dated May 2023, included polyethylene glycol 3350 one capful (17 grams) by mouth every other day. On May 17, 2023, at 7:21 a.m., the surveyor accompanied ULP-G to the nurse's office and discussed with licensed practical nurse (LPN)-K. LPN-K verified the order had changed, gave ULP-G a sticker to place on the bottle to indicate a change in the order, and stated she would call the pharmacy to make sure the label was changed to match the current order. LPN-K stated staff administering medications should always contact the nurse in-house or by phone if the medication administration record and the prescription label did not match. On May 19, 2023, at 12:30 p.m., RN-H provided a	01890		

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01890	Continued From page 49 copy of R9's prescriber orders, dated March 22, 2021 (more than two years ago), which indicated, "Change Miralax Powder [same as polyethylene glycol] to 17 grams-PO [by mouth]-QOD [every other day] and QOD PRN [as needed]." On May 22, 2023, at 11:01 a.m., CNS-A stated prescription labels on residents' medications should match the prescriber orders. The licensee's Medication and Treatment Orders policy, dated November 2022, indicated medication and treatment/therapy orders received by the licensee must be implemented within 24 hours of receipt by an RN, LPN, or therapist. The policy directed the RN was responsible for assuring that changes in orders were addressed in the resident's service plan and were communicated to the other staff; however, lacked direction to ensure the accuracy of prescription labels. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or	01910		

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	26585	A. BUILDING: _____ B. WING _____	05/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD SARTELL LLC	677 BRIANNA DRIVE SARTELL, MN 56377

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 50 expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one resident (R6) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R6's record lacked complete documentation of the disposition of the medications including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

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01910	Continued From page 51 R6 was discharged to a skilled nursing facility on December 26, 2022, after a stay in the hospital. R6 diagnoses included frontal temporal dementia (result of damage to neurons in the frontal and temporal lobes in the brain). R6's Service Plan dated effective May 5, 2022, noted services including medication administration. On May 16, 2023, at 2:49 p.m., clinical nurse supervisor (CNS)-A stated R6's Medication Disposition form included medications on December 5, 2022, and December 9, 2022, but stated this was not a complete list of R6's medications. In addition, CNS-A stated the disposition lacked information on Vitamin D3 and loperamide, and was not sure why this had not been documented with the required content along with the other medications. The licensee's Medication Disposition / Disposal (Controlled Substances) policy dated February 2023 noted documentation would include the name and strength, quantity, prescription number if available, date, and the signatures of appropriate personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The	01970		

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01970	Continued From page 52 order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of two residents (R3) who received treatments managed be the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on May 15, 2023, at 10:04 a.m., executive director (ED)-B and clinical nurse supervisor (CNS)-A stated the licensee provided treatment management services to the residents at the facility. R3's diagnoses included symptoms and signs involving cognitive functions and awareness, high blood pressure, retention of urine, and psychosis (loss of contact with reality). R3's Service Plan (Waiver) - Addendum to Contract, dated January 25, 2023, indicated R3 received services including assistance with	01970		

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01970	Continued From page 53 dressing, hygiene, anti-embolism stockings, behavior monitoring and management, catheter care, escort, peri care, and medication management. R3's Individual Treatment and Therapy Plan, dated March 17, 2023, included anti-embolism stockings, twice daily, and directed assistance with putting on and removal of anti-embolism stockings and washing them out at bedtime and hanging to dry. Staff were directed to notify the registered nurse (RN) if skin alteration noted or if the stockings were no longer fitting properly. The plan directed the RN to review and document effectiveness of treatment and provide education to the resident as needed, and communicate concerns to the provider. R3's prescriber orders, dated May 21, 2021, indicated "recommend compression stockings. Please measure & will mail appropriate size." On May 19, 2023, at 10:52 a.m., CNS-A stated she was aware that treatment orders must be renewed annually. The licensee's Medication & Treatment Orders policy, dated November 2022, indicated the licensed nurse would communicate with the prescriber to assure that the prescriber renewed medication or treatment/therapy orders at least every 12 months, or more frequently as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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02040	Continued From page 54	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on May 17, 2023, between approximately 12:35 p.m. and 12:50 p.m. with Executive Director (ED)-B	02040		

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02040	Continued From page 55 and Director of Maintenance (DM)-C on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with risk and mitigation factors on and around the property. During interview, ED-B stated that the licensee had performed a hazard assessment for the Appendix Z requirements but had not performed a hazard vulnerability assessment for the physical environment on or around the property and did not have any mitigation factors listed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based	02170		

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02170	Continued From page 56 on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized activity plan based on the activity evaluation, for three of three residents (R3, R4, R5) who resided in the assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with Dementia Care license, effective August 1, 2022, through August 31, 2023.	02170		

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02170	Continued From page 57 On May 15, 2023, at 11:26 a.m., the surveyors conducted a facility tour of the assisted living building and the memory care building, and noted activity calendars posted throughout each building. On May 16, 2023, at 10:08 a.m., eight residents were gathered in front of the television in the C-pod of the memory care building, as two staff tossed a ball around to each resident. R3 R3's diagnoses included symptoms and signs involving cognitive functions and awareness, and psychosis (loss of contact with reality). R3's Service Plan (Waiver) - Addendum to Contract, dated January 25, 2023, indicated R3 received services including assistance with dressing, hygiene, compression stockings, behavior monitoring and management, catheter care, escort, peri care, and medication management. R3's Leisure Activity Inventory, dated February 1, 2023, indicated R3 was interested in bingo, football, and pool, and enjoyed playing games, watching the Twins, and watching game shows. Also included, R3 preferred group activities, depending on the activity, and liked to play Scrabble. Staff were directed to encourage R3 to participation life enrichment activities. R3's record lacked an individualized activity plan based on the activity evaluation that reflected R3's activity preferences and needs, as required. R4 R4's diagnoses included Alzheimer's Disease, anxiety, type 2 diabetes, chronic obstructive	02170		

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02170	Continued From page 58 pulmonary disease, dementia, schizoaffective disorder (psychosis with mood symptoms), altered mental status, and personality disorder. R4's Service Plan (Waiver) - Addendum to Contract, dated January 25, 2023, indicated R4 received services including dressing, hygiene, showering, compression stockings, behavior monitoring, monthly vital sign monitoring, daily weights, assistance with toileting and peri care, safety checks, escorts, transfer assistance, and medication administration. R4's MC (memory care) - Life History and Memorable Moments, dated October 26, 2021, indicated R4's hobbies and interests included bingo, watching television (game shows), and games, and she preferred both solitary or group activities. R4 also had interest in playing cards, word games/puzzles, listening to music, group exercise, socials/parties, happy hour, and entertainment. R4 liked all animals, including cats and dogs. R4 had no difficulty with functional abilities relevant to activity participation and R4's family indicated "being involved" made R4 feel valued. R4's Individualized Activity Plan, dated May 12, 2023, indicated R4 needed full help to walk and depended on staff for routine escorts with stand by assist and four-wheeled walker to all destinations. The plan indicated R4 was interested in dice games, game shows, and bingo, and family and reading made her feel valued. R4 preferred both solitary or group activities and "Catholic" was noted as religious affiliation or preference. R4's record lacked an individualized activity plan based on the activity evaluation that reflected	02170		

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02170	Continued From page 59 R4's activity preferences and needs, as required. R5 R5's diagnoses included Parkinson's Disease, dementia, and frequent falls. R5's Service Plan (Private) - Addendum to Contract, dated January 25, 2023, indicated R5's services included assistance with dressing, hygiene, ambulation/exercise, compression stockings, behavior monitoring, escort, incontinent care, and medication administration. R5's MC - Life History and Memorable Moments, dated August 5, 2021, indicated R5 was a bookkeeper, hairdresser, and shop owner in the past, and liked to do activities with others. R5 enjoyed playing cards, bingo, listening to music, dancing, watching church on the television or listening on the radio, parties/socials, happy hour, and entertainment. On May 16, 2023, at 10:08 a.m., the surveyor observed eight residents gathered in the common area near the television in the "C Pod" of the Memory Care building, tossing a ball around the circle with two staff members. On May 18, 2023, at 1:06 p.m., activities (A)-I stated her supervisor (activities director (AD)-J) created the monthly activities calendar, and she distributed them to residents and posted them throughout each building. A-I stated announcements were made every morning and at lunch, in the dining room, to let residents know the scheduled activities for the day. A-I stated only activities on the calendar were "staffed," and the activities on the calendar took up most of the day. A-I stated the activity staff try to incorporate different levels of participation and they try to fit in	02170		

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02170	Continued From page 60 one-on-one activities with residents. On May 18, 2023, at 1:46 p.m., AD-J stated, in the past, they were required to spend at least 10-30 minutes per month, one-on-one with each resident, but the process had changed. AD-J stated, "We had more responsibility, but that's gone away. We don't spend time with them [residents] one-on-one." AD-J stated it was an ongoing process and their challenge had been how to get activities to everyone. AD-J stated they had not completed individual activity plans for the residents, as required. The licensee's Enrichment Programs, Activities & Outdoor Space policy, January 2022, indicated each resident must be evaluated for activities according to the licensing rules of the community and an individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request.	02260		

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02260	Continued From page 61 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, that included the frequency of training and the basic topics covered. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had an Assisted Living with Dementia Care license, effective August 1, 2022, through August 31, 2023. During the entrance conference on May 15, 2023, at 10:04 a.m., executive director (ED)-B stated the licensee had a secured dementia care facility in a building across the residential street from the assisted living facility, for residents with diagnoses of dementia or memory issues that required a secure environment. The licensee's MN (Minnesota) Disclosure of Special Care Status, revised April 2022, indicated the licensee would provide a written disclosure to the Commissioner of Health if requested, the Office of Ombudsman for Long-Term Care, and each person seeking placement within a residence, or the person's legal and designated	02260		

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02260	Continued From page 62 representatives, before an agreement to provide the care is entered into. The disclosure indicated all direct staff would be trained to work with residents with Alzheimer's disease and other dementias, and noted the trainings would be conducted "preservice and in-service;" however, lacked a description of the training program and the frequency of the training. In addition, the disclosure indicated the staff training would include understanding cognitive impairment, behavioral, and psychological symptoms of dementia, and standards of dementia care, including nonpharmacological dementia care practices that are person-centered and evidence informed; however, lacked required content to include assistance with activities of daily living and communication skills. On May 18, 2023, at 11:43 a.m., regional nurse director (RND)-D stated she believed the licensee's dementia disclosure included the required content, as it was obtained from a provider group. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02260		

DEPARTMENT OF HEALTH

Type: Full
Date: *05/15/23*
Time: 11:40:56
Report: 1037231122

Food and Beverage Establishment Inspection Report

Location:
Edgewood Sartell Llc
677 Brianna Drive
Sartell, MN56377
Stearns County, 73

Establishment Info:
ID #: 0038760
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202813343
ID #:

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

The following orders were issued during this inspection.

3-500E Microbial Control: time as a control

3-501.19A ***** Priority 2 *****

MN Rule 4626.0408A Develop written procedures prior to using time as a public health control for time/temperature control for safety food and maintain the procedures in the food establishment.

WHEN STORING TCS FOOD ITEMS ON ICE OR AT ROOM TEMPERATURE, SUCH AS CANTELOPE AND LETTUCE, THE FOOD ITEMS MUST BE CONSUMED OR DISCARDED WITHIN 4 HOURS OF REMOVING FROM MECHANICAL REFRIGERATION. DO NOT RETURN THE TCS FOODS TO TEMPERATURE CONTROL.

Comply By: 05/15/23

Surface and Equipment Sanitizers

Acid: = 272 at Degrees Fahrenheit
Location: SANITIZER BUCKET - KITCHEN 677
Violation Issued: No

Hot Water: = at 168 Degrees Fahrenheit
Location: DISHWASHER - KITCHEN 677
Violation Issued: No

Hot Water: = at 163 Degrees Fahrenheit
Location: DISHWASHER - KITCHEN 673
Violation Issued: No

Acid: = 700 at Degrees Fahrenheit
Location: SANITIZER BUCKET - KITCHEN 673
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 170 Degrees Fahrenheit - Location: BREADED FISH - KITCHEN 677
Violation Issued: No

Process/Item: Hot Holding
Temperature: 166 Degrees Fahrenheit - Location: SCALLOPED POTAOES - KITCHEN 677
Violation Issued: No

Process/Item: Hot Holding
Temperature: 151 Degrees Fahrenheit - Location: HAM - KITCHEN 677
Violation Issued: No

Process/Item: Hot Holding
Temperature: 173 Degrees Fahrenheit - Location: BRUSSEL SPROUTS - KITCHEN 677
Violation Issued: No

Process/Item: Hot Holding
Temperature: 151 Degrees Fahrenheit - Location: CHICKEN NOODLE SOUP - KITCHEN 677
Violation Issued: No

Process/Item: Time/Temp (HAACP)
Temperature: 53 Degrees Fahrenheit - Location: CUBED CANTELOPE - KITCHEN 677
Violation Issued: Yes

Process/Item: Time/Temp (HAACP)
Temperature: 33 Degrees Fahrenheit - Location: DICED PEPPERS & ONIONS - KITCHEN 677 ON ICE

Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: WILD RICE - KITCHEN 677
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: SHREDDED CHEESE - STORAGE ROOM 677
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: MILK JUG - KITCHEN 673
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 37 Degrees Fahrenheit - Location: TUNA PACKAGED - KITCHEN 673
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: POTATO SALAD - KITCHEN 673
Violation Issued: No

Process/Item: Hot Holding
Temperature: 168 Degrees Fahrenheit - Location: CAULIFLOWER - SERVING CART 673
Violation Issued: No

Type: Full
Date: *05/15/23*
Time: 11:40:56
Report: 1037231122
Edgewood Sartell Llc

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 164 Degrees Fahrenheit - Location: BEEF ROAST IN GRAVY - SERVING CART 673
Violation Issued: No

Process/Item: Hot Holding
Temperature: 176 Degrees Fahrenheit - Location: MASHED POTATOES - SERVING CART 673
Violation Issued: No

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

INSPECTED BOTH EDGEWOOD KITCHENS: LOCATE AT 673 BRIANNA DRIVE AND 677 BRIANNA DRIVE

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

I acknowledge receipt of the inspection report number 1037231122 of 05/15/23.

Certified Food Protection Manager: DIANE M WUEBKERS

Certification Number: 36418 Expires: 10/12/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Michelle L Hovanes

Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037231122

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 05/15/23
Time In 11:40:56
Time Out

Edgewood Sartell Llc	Address: 677 Brianna Drive	City/State: Sartell, MN	Zip Code: 56377	Telephone: 3202813343
License/Permit #: 0038760	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 05/15/23

Inspector (Signature) Michelle L Hoversos