Electronically Delivered

June 6, 2023

Licensee
Edgewood Blaine, LLC
12450 Cloud Drive Northeast
Blaine, MN 55449

RE: Project Number(s) SL29791015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 24, 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 . . ."

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

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

The correction order documentation should include the following:

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

the specific statute(s).

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

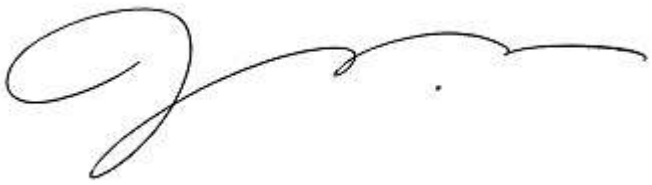
Please address your cover letter for reconsideration requests to:

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

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,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796
PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29791	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD BLAINE LLC	12450 CLOUD DRIVE NE BLAINE, MN 55449

(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: SL29791015 On May 22, 2023, through May 23, 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 sixty-two (62) active residents receiving services under the Assisted Living Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 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 had the potential to affect all residents in the Assisted Living 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated May 22, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by	0 660		

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0 660	Continued From page 2 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of one employee (director of nursing (DON)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB risk assessment dated February 1, 2023, indicated the licensee was a low risk setting for TB transmission.	0 660		

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0 660	Continued From page 3	0 660		

DON-A had a hire date of April 16, 2021. DON-A provided direct care to residents of the assisted living. DON-A's employee record lacked documentation of a two-step TST or other evidence of TB screening such as a blood test.

During an interview on May 22, 2023, at 1:30 p.m., DON-A stated she did not have evidence of TB testing and knew that she had a blood test for TB completed for a previous position and thought that she had provided this information to licensee. DON-A stated she was going to contact her health care provider to get the results.

On May 22, 2023, at 2:40 p.m., DON-A brought to surveyor a copy of a TB Gold blood test that she had completed on September 30, 2019. DON-A stated she believed that this was adequate as she knew that this type of blood test results were good for one year. Surveyor then reminded DON-A of her hire date of April 16, 2021. DON-A stated she thought she had started her employment with licensee in 2020.

The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, noted baseline screening for all health care workers (HCW) included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test.

The licensee's undated Tuberculosis Screening policy indicated staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients.

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0 660	Continued From page 4 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnection of smoke alarms inside the one-bedroom resident apartment units	0 780		

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0 780	Continued From page 5 105, 111, and 121. This has the potential to directly affect the residents in units 105, 111, and 121. 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: On May 24, 2023, approximately from 10:50 a.m. to 12:50 p.m., survey staff toured the facility with the regional vice president (RVP)-G. During the tour, the smoke alarm located in the one-bedroom resident units 105, 111, and 121 were not interconnected. The findings were evident when the RVP-G tested the smoke alarms in units 105, 111, and 121 by activating each smoke alarm and each sounded local. The RVP-G confirmed the findings. On May 24, 2023, at approximately 1:30 p.m., during the exit interview, the licensed assisted living director-F and the RVP-G acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 6 (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 the record review and interview, the licensee failed to provide the complete content of the fire safety and evacuation plan. This has the	0 810		

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0 810	Continued From page 7	0 810		

potential to directly affect the safety of all residents receiving services, 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), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

On May 24, 2023, at approximately 10:40 a.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the regional vice president (RVP)-G and the employee training records from the licensed assisted living director (LALD)-F at approximately noon. At approximately 1:15 p.m., document review and interview with the LALD-F, the assisted living director (ALD)-E, and the RVP-G on the fire safety and evacuation plan indicated the following findings on the facility fire safety and evacuation plan:

1. The plan lacked fire protection procedures for the assisted living residents. The LALD-F and the RVP-G verified that the plan lacked this provision.
2. The fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. Survey staff explained that unique situations or logistics during an evacuation may be residents who have mobility limitations, non-ambulatory, bedbound, cognitive impairment, or any residents needing additional assistance

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0 810	Continued From page 8 during an evacuation that must be addressed in the fire safety and evacuation plan documentation. During the interview, LALD-F and the RVP-G verified that the fire safety and evacuation plan for the facility lacked these provisions. On May 24, 2023, at approximately 1:40 p.m., during the exit interview, the LALD-F, the ALD-E, and the RVP-G acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
01760 SS=F	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 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 the steps of	01760		

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the medication administration process were followed for one of one employees, (unlicensed personnel (ULP)-H) observed during medication administration for two of two residents (R13, R14).

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:

R13

R13 was admitted on February 12, 2023 with a diagnosis of type II diabetes.

R13's medication assessment dated March 3,2023, indicated R14 was not assessed as being safe to self-administer medications.

R13's service agreement dated February 16, 2023, indicated R13 received assistance with medication administration.

R14

R14 was admitted on March 11, 2022 with a diagnosis of chronic systolic heart failure.

R14's medication assessment dated May 12, 2023, indicated R14 was not assessed as being safe to self-administer medications.

R14's service agreement dated March 9, 2022,

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indicated R14 received assistance with medication administration

ULP-H was hired on April 19, 2018, to provide direct care and services to the licensee's residents.

On May 23, 2023, at 7:45 a.m., the surveyor observed ULP-H administer R14's morning medications in the assisted living unit. ULP-H set up R14's morning medications from bubble packs (foil backed medication organizer) located in a locked medication cart to a medication cup. The surveyor observed ULP-H verify the medications to the medication administration record. ULP-H proceeded to entered the dining room and approached the dining table R14 was sitting at. There were 4 other residents eating breakfast in the dining area. ULP-H placed the medication cup on the table in front of R14 and exited the dining room; returning to the medication cart and documented in the electronic medical record (EMAR) that the medications had been administered.

Directly following the above observation ULP-H stated R14 liked staff to give her the medications so she could take them when she wanted.

On May 23, 2023, at 8:45 a.m., the surveyor observed ULP-H administer R13's morning medications. ULP-H removed R13's morning medications from a locked medication cart and popped each medication from a bubble pack into a medication cup. ULP-H entered the dining room and approached the dining table R13 was sitting at. There were 5 other residents in the dining area. ULP-H placed the medication cup on the table in front of R13 and exited the dining room; returning to the medication cart and documented

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in the EMAR that the medications had been administered. Directly following the above observation ULP-H stated most of the residents preferred to be given their medications at the dining table.

During interview on May 23, 2023, at 8:45 a.m., ULP-H stated she received medication and treatment administration training from a previous RN that no longer was employed with the licensee. ULP-H stated she most often would leave the medications with the resident when they were in the dining room and would go back to see if they had administered the medications. When asked, ULP-H stated neither R13 or R14 had a medication order written by a provider stating that they could self administer medications.

During interview on May 23, 2023, at 8:45 a.m., R13 stated that is was common that she received her medications in the common dining area as it was close to to the medication cart. R13 stated most of the time but not always the staff would return to the table to ensure R13 had taken her medications.

On May 23, at 10:15 a.m., director of nursing (DON)-A stated ULP's should remain with residents during medication administration, "they need to watch them take them" and "we agree it's not the correct process for medication administration." DON-A stated that it is not common practice for staff to leave medications with residents. DON-A also stated she was not sure why ULP-H would state that it was common to leave the medications with residents as ULP-H had not been working for several months and just recently returned to her position.

The licensee's Medication and Treatment Record

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01760	Continued From page 12 Policy dated February 2023, indicated documentation of medication/treatment/therapy reminders, medication/treatment/therapy assistance or medication/treatment/therapy administration will be completed by the person who performed the task immediately after the medication assistance/administration is completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain and monitor the temperature of medication storage refrigerators to ensure refrigerated medications were stored according to manufacturers' directions for seven residents (R2, R4, R7, R8, R9, R10, R11). 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).	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29791	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD BLAINE LLC	12450 CLOUD DRIVE NE BLAINE, MN 55449

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01880	Continued From page 13 The findings include: On May 23, 2023, at 9:05 a.m., the licensee's medication refrigerator, located in the memory care (MC) office, was observed with registered nurse (RN)-B. The refrigerator had a thermometer approximately 4x1 inches in size which read 41 degrees Fahrenheit (F). RN-B stated daily temperatures were logged into Rtask (charting software), Rtask prompted staff to check the temperature as one of their daily tasks. At 9:30 a.m., the following medications were observed in the MC medication refrigerator with RN-B present: -R2's Trulicity single-dose pens 0.75 milligram (mg) /0.5 milliliters (ml) dose, expiration date October 25, 2024; -R4's Novolin N FlexPen 3ml, 100 units (u)/ml, expiration November 30, 2024; -R7's Calcitonin Salmon Nasal Spray 200u bottle, 0.9 ml dispensed per spray, expiration January, 2025; -R8's Lantus SoloStar injection pen 100u/ml 3ml prefilled pen; expiration January 31, 2025; -R9's Victoza 18 milligram (mg)/3ml injection pens, expiration date February 28, 2025; -R10's Latanoprost 0.005% drops ophthalmic solution 125u/2.5ml; 2.5 ml bottle; expiration June, 2024; and -R11's Tresiba FlexTouch 100u/ml 3ml prefilled pens, expiration May 31, 2025. Rtask refrigerator temperature logs for April and May 2023, for MC and assisted living (AL) indicated, "Ensure the Medication Temperature log is recorded daily. Please write in the note section the degree of the medication refrigerator temperature. Temp MUST be between 36F-42 F. If the temperature is out of this range please	01880		

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01880	Continued From page 14 notify the on call RN **This must be a verbal call** Not an rtask message or text. This chore requires a note on recap. Please note the temp in the notes section and if you had to call the nurse on call." The logs indicated the following dates with temperatures out of range: MC REFRIGERATOR -April 17, 2023, 34 degree F, no chore note entered; -April 20, 2023, 44 degree F, turned up temp; -April 21, 2023, 70 degree F, nurse notified; -April 24, 2023, 34 degree F, changed temp and notified nurse; -April 26, 2023, 32 degree F, increased temp slightly; -April 30, 2023, 30 degree F, turned up fridge and let on call know; AL REFRIGERATOR -April 2, 2023, 50 degree F, lowered the temp in fridge so it can go back to normal; -April 6, 2023, 46 degree F, RN notified; -April 14, 2023, 44 degree F, no chore note entered; -April 19, 2023, 46 degree F, Notified [staff member name] licensed practical nurse (LPN); -April 21, 2023, 32 degree F, no chore note entered; -April 22, 2023, 30 degree F, no chore note entered; -April 23, 2023, 28 degree F, no chore note entered; -April 25, 2023, 44 degree F, no chore note entered; -April 28, 2023, 46 degree F, no chore note entered; -May 7, 2023, 45 degree F, no chore note entered; -May 12, 2023, 43 degree F, no chore note entered; -May 18, 2023, 44 degree F, no chore note	01880		

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01880	Continued From page 15 entered; On May 23, 2023, at 9:11 a.m., director of nursing (DON)-A stated Rtask had Medication Temperature logs and an out-of-range log which identified temperatures entered into Rtask which were outside of the required range of 36 to 42 degrees F, the temperature for the medication refrigerators were monitored daily for both MC and AL and logged by the staff member who checked it. The out-of-range log was blank which indicated Rtask did not recognize any temperatures outside of the required temperature range. DON-A stated if a temperature was out of range when logged it should show up on the out-of-range log. On May 23, 2023, at 9:30 a.m., RN-B stated if a medication temperature was out-of-range nursing would make an adjustment to the refrigerator thermostat. RN-B stated they would recheck temperatures within an hour to reassess the refrigerator temperature but there was no place to log the rechecked temperature. RN-B stated if the temperature got to the point it could not be stabilized maintenance would be notified to look at it. On May 23, 2023, at 10:32 a.m., DON-A stated staff were supposed to correct the refrigerator temperature immediately after finding out it was outside of parameters, staff were required to document a Chore Note which should explained the action taken. DON-A stated follow-up temperatures were checked the following day at the routine scheduled temperature check. DON-A stated they should also monitor the refrigerator temperature shortly after if any adjustments were made. DON-A stated medications should be moved to the other	01880		

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01880	Continued From page 16	01880		

refrigerator, in the AL office, if medications had prolonged exposure to temperatures outside of the required temperature range. Surveyor questioned if the pharmacy had been notified on April 21, 2023, when the temperature log indicated prolonged exposure to a temperature severely outside of the required temperature ranges of most refrigerated medications, DON-A stated staff should have but had no way of knowing if it was done but the expectation would be for staff to notify the pharmacy and get replacement medication if required. DON-A stated they were not documenting temperature rechecks, pharmacy calls, or medication relocation to their other medication refrigerator.

Manufacturer directions for Tresiba Flex Touch injection pen packaging dated 2015-2022, indicated to store unopened pens at 36 to 46 degrees F. Once the bottle is opened for use it may be stored between 36 to 86 degrees F.

Manufacturer directions for Novolin N FlexPen packaging copywrite 2020, indicated unopened pens could be stored refrigerated at 36 to 46 degrees Fahrenheit (F), do not freeze. Once in use it could be stored at 86 degrees F or below for 28 days.

Manufacturer directions for Lantus SoloStar injection pen packaging revised December 2020, indicated unopened pens could be stored refrigerated at 36 to 46 degrees F until the expiration date. Once in use it could be stored at room temperature (below 86 degrees F) for 28 days.

Manufacturer directions for Latanoprost Ophthalmic Solution packaging dated March 2022, indicated to store unopened bottles under

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01880	Continued From page 17 refrigeration at 36 to 46 degrees F. Once the bottle is opened for use it may be stored at room temperature up to 77 degrees F. Manufacturer directions for Victoza dated June 1, 2022, indicated store new/unused pens in the refrigerator at 36 to 46 degrees F. Do not freeze. Once in use store at 59 to 86 degrees F or in a refrigerator at 36 to 46 degrees F, discard after 30 days. Manufacturer directions for Calcitonin Salmon Nasal Spray dated November 1, 2022, indicated to store bottle unopened bottle in refrigerator at 36 to 46 degrees F. Protect from freezing. Once in use store at room temperature 68 to 77 degrees F for up to 35 days. Manufacturer directions for Trulicity pen injector revised December 2022, indicated, "Store Trulicity in the refrigerator at 36°F to 46°F (2°C [Celsius] to 8°C). If needed, each single-dose pen can be kept at room temperature, not to exceed 86°F (30°C) for a total of 14 days. Do not freeze Trulicity. Do not use Trulicity if it has been frozen." The licensee's Medication Refrigerator/Freezer Monitoring policy dated April 2022, indicated, "Staff (usually an unlicensed staff) must check weekly, or more often as state regulation requires, confirming that the refrigerator used to store medications maintains temperature between 36 and 46 degrees." The licensee's Medication Storage policy, undated, indicated, "Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen)." No further information provided.	01880		

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01880	Continued From page 18 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02410 SS=F	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for one of one resident (R13) observed during treatment administration.	02410		

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02410	Continued From page 19	02410		

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

The findings include:

R13 was admitted on February 14, 2023, with a diagnosis of type two diabetes mellitus. R13's service agreement was dated February 16, 2023, and indicated R13 received assistance with medication administration, blood glucose monitoring, and blood pressure monitoring.

ULP-H was hired on April 19, 2018, to provide direct care and services to the licensee's residents.

On May 23, 2023, at 7:45 a.m., R13 walked up to the medication cart where unlicensed personnel (ULP)-H was dispensing medications. R13 asked ULP-H if she would be receiving her blood glucose test before she would be eating breakfast. ULP-H stated she would assist her as soon as possible. R13 then proceeded to sit at a dining room table in the common dining area.

On May 23, 2023, at 7:55 a.m., ULP-H gathered supplies to complete a blood glucose test for R13 (gloves, blood glucose monitor, finger lancet, alcohol wipe) and proceeded to walk to the dining room table where R4 was seated. ULP-H began to remove the blood glucose machine from its holder, placed gloves on both hands, and was in the process of removing the cap of the finger

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02410	Continued From page 20	02410		

lancet. Director of nursing (DON)-A was walking into the nurse office when she viewed ULP-H proceeding to obtain a blood glucose test for R13. DON-A stated to ULP-H that a blood glucose test could not be done in a common area and must be completed in private. ULP-H then asked R13 to follow her into the nurse office to complete the blood glucose test in private. R13 agreed and followed ULP-H into the office where the door was closed, and the blood glucose testing was completed.

On May 23, 2023, at 8:10 a.m., R13 left the nursing office and returned to the dining table where R13 had been previously sitting. ULP-H proceeded to medication cart where she placed blood glucose monitoring supplies back into the medication cart. After cleansing hands with hand sanitizer, ULP-H gathered an electronic blood pressure monitor and proceeded to the dining table where R13 was seated. ULP-H then placed a blood pressure cuff onto R13's right arm and obtained R13's blood pressure using the electronic blood pressure measuring device. After completion, ULP-H removed the blood pressure cuff, turned off the machine, and proceeded to the medication cart where ULP-H documented results of the blood pressure for R13 in the electronic medical record.

During interview on May 23, 2023, at 8:35 a.m., ULP-H stated that she received medication and treatment administration training from a previous registered nurse (RN) that no longer was employed with licensee. ULP-H stated it was common to complete blood glucose test and blood pressure monitoring in the dining area and ULP-H stated she was not aware this was a privacy issue. ULP-H stated she could not remember if this was taught to her during her

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02410	Continued From page 21 training. During interview on May 23, 2023, at 8:45 a.m., R13 stated that it was common that she received her blood glucose testing and blood pressure monitoring in the common dining area as it was close to the medication cart. During interview on May 23, 2023, at 11:10 a.m., DON-A stated that all staff performing any task for a resident should complete the task in a private area and away from other residents or staff. DON-A stated all staff have been educated on resident personal privacy. The licensee's Continuous Blood Glucose Competency form, dated February 2023, indicated staff were to explain the procedure and provide privacy to the resident before completing a blood glucose test. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *05/22/23*
Time: 12:30:00
Report: 10392350

Food and Beverage Establishment Inspection Report

Location:
Edgewood Blaine Llc
12450 Cloud Drive Ne
Blaine, MN55449
Anoka County, 02

Establishment Info:
ID #: 0038869
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637547123
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.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT HAS A DISK-TYPE THERMOMETER FOR MEASURING HOT DISH MACHINE WATER WHICH IS MALFUNCTIONING. DISCUSSED WITH STAFF REPAIRING OR REPLACING THIS THERMOMETER.

Comply By: 05/22/23

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

BOTTOM MANIFOLD OF MEAT SLICER IS CONTAMINATED WITH FOOD DEBRIS. DISCUSSED WITH STAFF TO ADD THIS PART TO CLEANING ROUTINE.

Comply By: 05/22/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

PERSON IN CHARGE HAS COMPLETED SERVSAFE COURSE. SUBMIT CERTIFICATE OF COMPLETION TO MDH TO OBTAIN CFPM. INFORMATION ON CFPM EMAILED TO PERSON IN CHARGE.

Comply By: 05/22/23

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

MICROWAVE INNER SURFACES ARE SOILED WITH FOOD DEBRIS. DISCUSSED WITH STAFF TO CLEAN REGULARLY.

Comply By: 05/22/23

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

HOT WATER ON LEFT FAUCET AT 3-COMPARTMENT SINK IS LEAKING. HOT WATER ON FAUCET AT DISH WASHING LINE IS LEAKING. DISCUSSED WITH STAFF TO CONTACT FACILITIES/MAINTENANCE TO REPAIR.

Comply By: 06/19/23

Surface and Equipment Sanitizers

Hot Water: = at 170 F Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Lactic Acid & DDBSA: = 700 PPM at Degrees Fahrenheit
Location: 3-COMP SINK DISPENSER
Violation Issued: No

Lactic Acid & DDBSA: = 700 PPM at Degrees Fahrenheit
Location: WIPING CLOTHE BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 39 Degrees Fahrenheit - Location: COLD HOLD TRUE COOLER EXPO
Violation Issued: No

Process/Item: COOKED POTATOES
Temperature: 171 Degrees Fahrenheit - Location: HOT HOLD EXPO COUNTER
Violation Issued: No

Process/Item: COOKED CHICKEN
Temperature: 177 Degrees Fahrenheit - Location: HOT HOLD EXPO COUNTER
Violation Issued: No

Process/Item: NOODLE SOUP
Temperature: 166 Degrees Fahrenheit - Location: HOT HOLD EXPO COUNTER
Violation Issued: No

Process/Item: WHOLE MILK
Temperature: 39 Degrees Fahrenheit - Location: COLD HOLD DELFIELD 6000
Violation Issued: No

Type: Full
Date: *05/22/23*
Time: 12:30:00
Report: 10392350
Edgewood Blaine Llc

Food and Beverage Establishment Inspection Report

Process/Item: COOKER PASTA
Temperature: 39 Degrees Fahrenheit - Location: COLD HOLD WALK IN COOLER
Violation Issued: No

Process/Item: LETTUCE
Temperature: 40 Degrees Fahrenheit - Location: COLD HOLD WALK IN COOLER
Violation Issued: No

Process/Item: EGG SALAD
Temperature: 39 Degrees Fahrenheit - Location: COLD HOLD DELFIELD
Violation Issued: No

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

The inspection was completed with the person in charge and reviewed with MDH Nurse Elyse Jones.

The establishment has a commercial grade kitchen. There is an expo area with sink, cooler/freezer, ice machine and hot holding steam wells built into counter. This area has laminate wood floors and laminate countertops. The finishes in this area are well maintained and in good repair.

Discussed with staff hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 10392350 of 05/22/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Martrez Burrell
Dining Services Director

Signed:_____
Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us