DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

July 6, 2023

Licensee
Edgewood EGF Senior Living
608 5th Avenue Northwest
East Grand Forks, MN 56721

RE: Project Number(s) SL30631015

Dear Licensee:

On June 29, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the May 24, 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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

PMB

Electronically Delivered

June 8, 2023

Licensee
Edgewood EGF Senior Living
608 5th Avenue Northwest
East Grand Forks, MN 56721

RE: Project Number(s) SL30631015

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,

Jessica Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(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#30631015 On May 22, 2023, through May 24, 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 36 active residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 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		
0 485 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 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	0 485		

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0 485	Continued From page 2 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 observation, interview and record review, the licensee failed to post a menu a week in advance that was made available to all residents. This had the potential to affect all residents. 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 22, 2023, at approximately 10:15 a.m., during a tour of the facility with clinical nurse supervisor (CNS)-C and licensed assisted living director (LALD)-A, the surveyor observed a daily menu board posted in unit E which was the main entrance of the facility and near the main working kitchen. The board noted the menu for the day. During the tour the surveyor observed menus posted on refrigerators located in open kitchens	0 485		

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0 485	Continued From page 3 on unit B and unit C. Unit B's menu noted, Tuesday, day 24: Breakfast: oatmeal, toast, sausage, breakfast fruit; Lunch: pork loin, garlic buttered noodles, mixed vegetables, bread stick, fruit; Dinner: tomato soup, grilled cheese, diced tomato salad, fruited gelatin. This was the only menu posted in the general area. Unit C's menu noted, Saturday, day 28: Breakfast: fried egg, bacon, hot or cold cereal, breakfast fruit, toast; Lunch: brown sugar glazed ham, baby bakers, baby carrots, bread/margarine, fruit; Dinner: ham and cheese on bun, potato salad, rice krispie bar, baked beans. This was the only menu posted in the general area. On May 22, 2023, at 10:27 a.m., LALD-A stated he was not aware weekly menus needed to be made available to the residents; posted and/or given to the residents. LALD-A said he changed the menu for the day. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an	0 630		

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0 630	Continued From page 4 individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for one of three residents (R4). 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: R4's diagnoses included Alzheimer's disease, diabetes, overactive bladder, and agitation. R4's service plan dated March 15, 2023, indicated the resident received services which included behavior monitoring, catheter care, medication administration, blood glucose monitoring and safety checks. On May 23, 2023, at 8:36 a.m., the surveyor	0 630		

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0 630	Continued From page 5 observed unlicensed personnel (ULP)-F administer R4's oral medication and insulin. R4's Individual Abuse Prevention Plan (IAPP) dated March 16, 2023, identified areas of vulnerability with interventions and a review of the resident's susceptibility to be abused by another individual, including other vulnerable adults. R4's IAPP did not include a review of the resident's risk of abusing other vulnerable adults. On May 23, 2023, at 1:02 p.m., regional nursing director (RND)-H stated R4's abuse prevention plan did not contain all the required content. RND-H added the nurse who completed the assessment did not "click" a box to generate all the options available. The licensee's Abuse Prevention, Intervention, Reporting and Investigation policy dated February 2023, noted residents are to be free from verbal, sexual, physical, emotional/mental abuse, neglect, self-abuse/self-neglect, medication neglect, misappropriation of resident property, exportation, and involuntary seclusion at all times. The Community has developed a system for identifying, investigating, preventing, and reporting any incident, or suspected incident, of abuse as defined above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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0 680	Continued From page 6 requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to prominently post a written emergency preparedness plan (EPP) with all the required content. In addition, the licensee failed to post exit diagrams. This had the potential to affect all residents, staff, and visitors of the 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	0 680		

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0 680	Continued From page 7 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 22, 2023, at approximately 10:30 a.m., the surveyor observed the entry area, common areas, and dining area within the facility with licensed assisted living director (LALD)-A. The surveyor did not observe signage posted or information regarding the licensee's EPP. LALD-A pointed to a flip chart hanging on the wall by a desk area, titled Emergency Procedure Guide, undated. The sections were labeled: -General emergency procedures/ 911 Shelter assemble areas -Crime reporting -Fire, Smoke or Explosion- code red -Tornado/Severe Weather-code black -Medical emergency- code blue -Elopement- missing person- code gray -Safety concerns-code yellow -Mechanical shut off -Hazardous material spills -Bomb threat -Emergency phone numbers. On May 22, 2023, at 2:39 p.m., the surveyor and LALD-A reviewed the EPP binder in LALD-A's office. LALD-A stated the EPP was not posted in the common areas of the facility and confirmed the following: The licensee's EPP dated March 17, 2023, failed to include: -procedures for tracking of staff and residents; -contact information for ombudsman; and -communication plan, method for sharing information from the emergency plan, with	0 680		

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0 680	Continued From page 8 residents and their families/representatives. EXIT DIAGRAM On May 22, 2023, at approximately 10:30 a.m., during facility tour with LALD-A, the surveyor did not observe an exit diagram posted in the main entry of the facility, unit E. LALD-A stated the walls were repainted and the diagrams were removed. On May 22, 2023, at 10:34 a.m., the surveyor observed an exit diagram in unit D that included five bedrooms, restroom, kitchen and outside area. The diagram did not include units A, B, C, and E. On May 22, 2023, at 11:13 a.m., clinical nurse supervisor (CNS)-C stated the exit diagram posted in unit D was not complete. The licensee's Emergency Preparedness policy, undated, noted the facility emergency preparedness plan would include all required elements of appendix Z. The plan would be in writing and reviewed annually. The plan was based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan included four primary components: -risk assessment and planning; -policies and procedures; -a communication plan; and -staff training and exercises/drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 790	Continued From page 9	0 790		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide fire extinguishers that were accessible during an emergency event. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on May 22, 2023, at approximately 10:30 a.m. with Maintenance-EE, it was observed that fire extinguishers were	0 790		

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0 790	Continued From page 10 fastened to the extinguisher brackets with bungy cords. This condition was noted in the kitchen and dining area and made removal of the fire extinguishers difficult in the event of an emergency. This deficient condition was visually verified by Maintenance-EE accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 970		

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0 970	Continued From page 11 the residents). The findings include: The facility's Resident Agreement (assisted living contract) and Resident Handbook (considered part of the assisted living contract) were reviewed. The Resident Agreement indicated in section 17. Resident Policies, Rules and Regulations "By signing this Agreement, you [resident] agree to abide by and comply with all of the Community's policies, rules and regulations, which have been provided to you in the Resident Handbook. The Resident Handbook is incorporated in and considered part of this Agreement". The Resident Handbook included a clause that indicated the resident would waive the facility's liability for personal property of the resident. Page four, section Valuables of the Resident Handbook indicated the "[name of facility] staff would exercise every effort possible to prevent the loss or breakage of residents' personal processions. However, if loss or breakage should occur, [name of facility] is not responsible for replacement". On May 23, 2023, at 1:13 p.m., licensed assisted living director (LALD)-A stated the Resident Agreement had been revised, however, the Resident Handbook had not been. LALD-A stated he was aware this language noted above waived the facility's liability. LALD-A stated the Resident Agreement and Resident Handbook were provided to all residents. No further information was provided. TIME PERIOD FOR CORRECTION:	0 970		

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EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(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
0 970	Continued From page 12 Twenty-One (21) days	0 970		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and	01060		

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01060	Continued From page 13 (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content to the resident, legal representative, and designated representative; and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for two of two residents (R1, R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1's diagnosis included memory problems, fatigue, and rheumatoid arthritis. R1's service plan not available. R1's medication assessment dated December 2, 2021, noted R1 needed help with taking	01060		

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01060	Continued From page 14 medication, medication administration. R1's "notes" included the following: -January 1, 2023, resident was taken by EMS (emergency medical service) to ER (emergency room) for evaluation. -January 2, 2023, update received from hospital, aspiration pneumonia receiving antibiotics. -January 25, 2023, R1 receiving total assist of one (1) for transfers and cares. Skilled care recommended and it was decided to keep R1 at skilled care and give up R1's apartment. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. R8 R8's diagnosis included Alzheimer's dementia without behavioral disturbance, depression, and anxiety disorder.	01060		

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	30631	A. BUILDING: _____ B. WING _____	05/24/2023

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01060	Continued From page 15 R8's service plan not available. R8's medication assessment dated December 16, 2018, noted R8 needed help with taking medication, medication administration. R8's "notes" included the following: -December 23, 2022, EMS was dispatched, vitals taken and determined R8 should be taken to hospital. Emergency packet was printed, given to EMS and message was left for R8's son. -January 10, 2023, R8 planning to transfer to (name of facility) for rehab. -January 30, 2023, R8 discharging from facility due to his requirement of skilled care after recent hospitalization. R8's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R8's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On May 22, 2023, at approximately 11:00 a.m.,	01060		

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01060	Continued From page 16 clinical nurse supervisor (CNS)-A stated he was not aware if OOLTC had been notified, adding he had not been at the facility long enough. On May 22, 2023, at 2:15 p.m., registered nurse (RN)-B stated she did not "think" any notice was given to OOLTC regarding R1 and R8's leaves from the facility. On May 22, 2023, at approximately 3:00 p.m., RN-B stated OOLTC had not been contacted regarding R1 and R8's leave. The licensee's Emergency Relocation policy revised September 2022, noted the licensee may remove a resident from the facility in an emergency if necessary due to a resident's urgent medication needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. In the event of an emergency relocation, the licensee would provide a written notice that contained, at a minimum: -the reason for the relocation -the name and contact information for the location to which the resident had been relocated and any new service provider -contact information of the Office of Ombudsman for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities -if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known, and -a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal. The notice required would be delivered as soon as practical to:	01060		

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01060	Continued From page 17 -the resident, legal representative, and designated representative -for resident who received home and community-based waiver services, the resident's case manager, and -the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility within four days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01690 SS=D	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and	01690		

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	30631	A. BUILDING: _____ B. WING _____	05/24/2023

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01690	Continued From page 18	01690		

designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure the security and accountability of controlled substances were maintained for one of three residents (R3).

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:

On May 22, 2023, at 9:55 a.m., during the entrance conference registered nurse (RN)-B stated all narcotic medication was double locked and counted by two staff members at the end/start of each shift.

On May 22, 2023, at 11:11 a.m., the surveyor toured the facility with registered nurse (RN)-B, including a review of the locked medication cupboard in the locked medication room. The medication cupboard contained a bottle of R3's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01690	Continued From page 19	01690		

liquid morphine sulfate (narcotic pain reliever) 100 milligrams/5 milliliters (mg/ml). RN-B visualized R3's bottle of morphine and stated there currently was approximately 28.8 ml of morphine sulfate in the bottle. The two narcotic log forms for R3's morphine sulfate was reviewed with RN-B and the following was verified by RN-B:
- The Individual Narcotic Record in the bound narcotic book for R3's morphine sulfate dated May 4, 2023, through May 10, 2023, noted on the last entry dated May 10, 2023, there was 30 ml of morphine in the bottle.
- The Narcotic Record located in the narcotic three-ring binder for R3's morphine sulfate indicated on May 10, 2023; 28.8 ml of morphine sulfate was received. The rest of this Narcotic Record was blank (leaving a discrepancy of 1.2 ml [equivalent to 24 mg] of morphine sulfate).

On May 22, 2023, at 11:20 a.m., RN-B stated she was unsure why R3's morphine count was off and that she would need to speak with clinical nurse supervisor (CNS)-C. RN-B stated R3's liquid morphine was only counted when medication was removed from the bottle and witnessed by two staff, not every shift as directed in the licensee's policy.

On May 23, 2023, at 9:30 a.m., RN-B stated an incident report and investigation had been completed with regards to R3's unaccounted for 1.2 ml of morphine sulfate. RN-B stated 12 syringes of 0.1 ml of morphine sulfate had been filled for R3, and the nurse who set them up did not deduct the 1.2 ml from the total of 30 ml, leaving a total of 28.8 ml in the morphine bottle.

The licensee's undated Medication Storage policy noted scheduled II drugs [morphine sulfate is a

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01690	Continued From page 20 scheduled II medication] would be counted at the beginning and end of every shift, with counts compared to scheduled II medications ordered to be administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690		
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 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 have medications available to administer as ordered for two of three residents (R2, R4) and failed to ensure medications were administered per manufacturer's instructions for two of three residents (R2, R4) observed during medication administration.	01760		

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01760	Continued From page 21 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: MEDICATION SUPPLY R2 R2's diagnoses included Alzheimer's disease, congestive heart failure (CHF-a condition in which the heart's function as a pump is inadequate to meet the body's needs), hypertension (HTN- high blood pressure), and asthma. R2's Individualized Medication Management Plan dated April 28, 2023, indicated the licensee's staff would prepare and administer R2's medications as ordered by the provider and the licensed nurse was responsible for monitoring medication supplies and reordering as needed. R2's prescriber orders dated May 11, 2023, included an order for the following medications: - aspirin 325 milligrams (mg) (heart health medication) to be administer twice daily - bisacodyl 5 mg (laxative) to be administered daily - celecoxib 200 mg (anti-inflammatory) to be administered daily - multivitamin one tablet to be administered daily - sertraline 150 mg (antidepressant) to be administered daily - atorvastatin 20 mg (high cholesterol) to be administered at bedtime	01760		

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01760	Continued From page 22 - gabapentin 300 mg (nerve pain) to be administered at bedtime R2's May 1, 2023, through May 23, 2023, medication administration record (MAR) indicated R2 did not receive the following scheduled medications as prescribed: - aspirin 325 mg scheduled 8:00 a.m. and 8:00 p.m., dose not given nine (9) times out of 43 opportunities; - bisacodyl 5 mg scheduled 8:00 a.m., dose not given 11 times out of 23 opportunities; - celecoxib 200 mg scheduled 8:00 a.m., dose not given 10 times out of 23 opportunities; - multivitamin one tablet scheduled 8:00 a.m., dose not given seven (7) times out of 23 opportunities; - sertraline 150 mg scheduled 8:00 a.m., dose not given nine (9) times out of 22 opportunities; - atorvastatin 20 mg scheduled 8:00 p.m., dose not given three (3) times out of 22 opportunities; and - gabapentin 300 mg scheduled 8:00 p.m., dose not given eight (8) times out of 22 opportunities. R2's May 1, 2023, through May 23, 2023, MAR included documentation which indicated the above noted medications had not been administered as ordered due to "med [medication] out of stock" or "medication not available". R4 R4's diagnoses included Alzheimer's disease, diabetes, overactive bladder, and agitation. R4's Individualized Medication Management Plan dated March 16, 2023, indicated the licensee's staff would prepare and administer R4's medications as ordered by the provider and the	01760		

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01760	Continued From page 23 licensed nurse was responsible for monitoring medication supplies and reordering as needed. R4's prescriber orders dated May 9, 2023, included an order for the following medications: -Ativan 1 mg (anxiety) to be administered twice daily -cetirizine 5 mg (allergies) daily -gemtesa 75 mg (overactive bladder) to be administered daily -Lantus insulin 100 units/ milliliters (ml) 20 units (long-acting insulin) to be administered daily -Miralax 17 grams (bowel health) to be administered every other day -multivitamin one tablet to be administered daily -Novolog insulin 100 units/ml 6 units (fast-acting insulin) to be administered with meals -omeprazole 20 mg (heartburn) to be administered twice daily -quetiapine 25 mg (behaviors) to be administered three times daily -simvistain 20 mg (high cholesterol) to be administered at bedtime -tamsulosin 0.4 mg (enlarged prostate) to be administered at bedtime R4's May 1, 2023, through May 23, 2023, MAR indicated R4 did not receive the following scheduled medications as prescribed: -aspirin 81 mg scheduled 8:30 a.m. dose not given five (5) times out of 22 opportunities; -Ativan 1 mg scheduled 8:30 a.m., and 4:00 p.m., dose not given five (5) out of 43 opportunities -cetirizine 5 mg scheduled 8:30 a.m., dose not given five (5) out of 22 opportunities; -gemtesa 75 mg scheduled 8:30 a.m., dose not given eight (8) out of 14 opportunities; -Miralax 17 grams scheduled 4:00 p.m., dose not given one (1) out of 10 (ten) opportunities; -multivitamin one tablet scheduled 8:30 a.m.,	01760		

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01760	Continued From page 24 dose not given seven (7) out of 22 opportunities; -quetiapine 25 mg scheduled 8:00 a.m., 12:00 p.m., and 4:00 p.m., dose not given eight (8) out of 65 opportunities; and -simvistain 20 mg scheduled 8:00 p.m., dose not given one (1) out of 22 opportunities. On May 23, 2023, at approximately 9:00 a.m., registered nurse (RN)-B stated the facility had problems getting medications from one of the two pharmacies used. Clinical nurse supervisor (CNS)-C said he was not sure why medications marked as given on Saturday and Sunday were documented as not being available on Friday and Monday during the same week. On May 23, 2023, at 1:02 p.m., regional nursing director (RND)-H stated her "guess" would be after three days of missing a medication action should be taken. On May 23, 2023, at 1:05 p.m., RN-B and CNS-C reviewed R2's May 2023 MAR and stated the above noted medications had not been administered to R2. RN-B stated the staff who pass medications were trained when a resident needed a medication refilled the staff were to complete a medication "refill" form and give it to the nurse. RN-B stated once the nurse received the "refill" form; the nurse would fax the form to the pharmacy. CNS-C stated the facility has had problems with the pharmacies responding timely to the refill requests. On May 24, 2023, at 8:41 a.m., RN-B and CNS-C stated they were unaware R2 had missed the medication doses noted above. RN-B stated R2's provider had not been notified of the missed doses of medication. CNS-C stated he had not observed any changes with R2 regarding her not	01760		

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	30631	A. BUILDING: _____ B. WING _____	05/24/2023

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EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

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01760	Continued From page 25 receiving the above noted scheduled medications. The licensee's undated Medication and Supplies - Reordering policy, noted nursing staff would assist residents to make sure medications and supplies are ordered and available as needed. When a resident needs medication and/or supplies reordered the from the pharmacy or supplier, staff will contact them by faxing, calling, or following the pharmacy's directions for refilling prescriptions or requests. FOLLOWING MANUFACTURER'S INSTRUCTIONS R2 R2's diagnoses as noted above. R2's service plan and assessment dated April 26, 2023, and May 12, 2023, respectively, indicated the resident received medication management services to include medication administration. R2's prescriber orders dated May 11, 2023, included an order for Advair Diskus 250/50 micrograms (mcg) (bronchodilator) one puff to be inhaled in the morning with instructions to "rinse mouth with water and spit out after each use to prevent fungal infection." On May 23, 2023, at 8:13 a.m., the surveyor observed unlicensed personnel (ULP)-F conduct a medication pass for R2 which included administration of the Advair Diskus 250/50 mcg inhaler. ULP-F activated the Advair Diskus inhaler; handed the inhaler to R2; R2 took a long, fast breath in; R2 handed the inhaler back to ULP-F. ULP-F then returned to the medication cart. ULP-F did not instruct R2 to rinse her mouth out after the administration of the Advair	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

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01760	Continued From page 26 Diskus inhaler. On May 23, 2023, at 8:14 a.m., directly following the above observation, the surveyor and ULP-F reviewed R2's electronic medication administration record (EMAR) and ULP-F read the instructions for the Advair Diskus inhaler which included to have R2 rinse her mouth out with water after use. ULP-F stated he had not instructed R2 to rinse her mouth out after the administration of the Advair Diskus inhaler and he should have. On May 23, 2023, at 9:04 a.m., RN-B stated following the administration of an Advair Diskus inhaler the staff should instruct the resident to rinse their mouth out with water to prevent a fungal infection. The manufacturer's instructions for use of the Advair Diskus inhaler, dated August 2020, indicated one should rinse their mouth with water after use and spit the water out. Do not swallow the water. The licensee's Giving Inhaled Medications - Checklist policy dated November 2018, directed to have the resident rinse his or her mouth with water if he or she inhaled a cortico-steroid. R4 R4's diagnoses as noted above. R4's service plan dated March 15, 2023, indicated the resident received medication management services to include medication administration. On May 23, 2023, at 8:35 a.m., the surveyor observed ULP-F remove R4's Novolog insulin	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 27	01760		

pen (a multiple dose pen shaped injector device for insulin administration) and a needle from the medication cart. With gloved hands ULP-F attached the needle to R4's Novolog pen. ULP-F primed the insulin pen, gathered medication, alcohol pad and went to R4's room to administer medication. The surveyor did not observe ULP-F clean the tip of the insulin pen prior to attaching the needle.

Directly after the above observation ULP-F said he "usually" cleans the insulin pen with alcohol pad prior to securing the needle, adding he was nervous.

On May 23, 2023, at 10:39 a.m., CNS-C stated he checked the facility's policy, the insulin pen should have been cleaned with alcohol prior to applying the needle.

The manufacturer's instructions for use of the Novolog Flexpen, dated January 2019, directed to remove the pen cap to check the insulin;
-do not use insulin that is cloudy or not clear, or if it has any specks;
-wipe the pen tip with an alcohol pad;
-removed the seal on the needle cap; and
-twist or push (based on the needle type) the needle straight onto the pen tip.

The licensee's Insulin Administration By Pen Competency procedure dated February 2023, noted gather supplies, wash hands, put on gloves, compare the insulin pen label with the MAR, check the expiration date, removed insulin open cap, clean rubber stopper with an alcohol swab, take out new packaged needle, removed protective tab, do not touch where the needle was attached to the pen, carefully attach the needle to the pen and removed the protective cap.

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	30631	A. BUILDING: _____ B. WING _____	05/24/2023

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01760	Continued From page 28 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days Surveyor: Casey, Cyndi E.	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R3). 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: During the entrance conference on May 22, 2023, at 9:56 a.m., clinical nurse supervisor (CNS)-C stated the licensee provided medication	01770		

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	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01770	Continued From page 29 management services which included medication setup. R3's diagnoses included cognitive disorder, anxiety, aphasia (a brain disorder which affects a person's ability to express and understand written and spoken language), and hyperlipidemia (high cholesterol). R3's service plan dated April 14, 2023, and Individualized Medication Management Plan dated May 8, 2023, indicated R3 received medication management services to include medication setup and administration. R3's prescriber orders dated April 12, 2023, included an order for morphine sulfate (narcotic pain reliever) 2 milligrams (mg) every one hour as needed for pain/dyspnea (shortness of breath). On May 22, 2023, at 11:05 a.m., the surveyor toured the facility with CNS-C, including a review of the locked medication cart. Observed in the medication cart was a clear plastic baggie with the following information handwritten with black marker on the outside of the plastic baggie, "[R3's first name and initial of last name] prn [as needed] syringes." The baggie contained twelve unlabeled preset 0.1 milliliter (ml) syringes. CNS-C stated the preset syringes were morphine sulfate and had been setup by a licensed nurse. R3's record lacked documentation for medication setup at the time of setup to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, route of administration and name of person completing medication setup. On May 23, 2023, at 2:40 p.m., registered nurse	01770		

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	30631	A. BUILDING: _____ B. WING _____	05/24/2023

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EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

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01770	Continued From page 30 (RN)-B stated medication setup for R3's morphine had not been documented as required. RN-B stated the licensee's electronic documentation system didn't have a good place to document medication setup and this would be the same for all residents who had medication setup services. The licensee's undated Medication Management policy noted a licensed nurse would correctly and accurately document any medication setup provided. Medications that cannot be setup in the dosage box (topical or liquid) will be recorded on the medication administration record (MAR) to include any special instructions and the medication name, quantity of dose, times to be administered, route of administration, visual description of medication, drug classification and special precautions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
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 ensure one of one medication refrigerator maintained an acceptable temperature to ensure the medications were	01880		

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	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 31 stored according to manufacturer's recommendations. In addition, the licensee failed to ensure medications were secure and permitted access to only authorized personnel for one of two medication carts (A-B-C-D unit medication cart). 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: STORAGE OF MEDICATIONS On May 22, 2023, at 10:39 a.m., the surveyor reviewed the locked medication refrigerator with registered nurse (RN)-B and clinical nurse supervisor (CNS)-C. RN-B stated the current temperature of the medication refrigerator was 34-35 degrees Fahrenheit (F). The surveyor observed on the bottom of the inside of the refrigerator was a pool of water which had soaked through a couple of the boxes which stored insulin pens. RN-B stated the freezer/refrigerator "must not be working". CNS-C stated the temperature of the medication refrigerator was checked daily and recorded in the electronic log. CNS-C was not aware of the acceptable temperature range for the medication refrigerator. At 10:46 a.m., RN-B reviewed a Lantus insulin packaging box and stated the current temperature of the medication refrigerator was lower than the acceptable range of 36-46 degrees F.	01880		

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01880	Continued From page 32 The medication refrigerator contained the following medications: - six unopened Lantus 100 units/milliliter (ml) insulin pens (a multiple dose pen shaped injector device for insulin administration) (long-acting) - six unopened Levemir (long-acting) 100 units/ml insulin pens (long-acting) - one unopened Ozempic 2 milligrams/1.5 ml pen (lower blood sugar) - one unopened bottle of latanoprost ophthalmic solution (a glaucoma eye drop solution) On May 22, 2023, at 12:30 p.m., the surveyor reviewed the medication refrigerator temperature log dated May 1, 2023, through May 22, 2023, with RN-B. RN-B stated the medication refrigerator temperature was scheduled to be checked twice a day. The temperature of the refrigerator had been recorded 34 out of 43 opportunities. Of the 34 times the temperature had been recorded; 17 times out of the 34 opportunities the temperature was either above or below the acceptable range of 36 to 46 degrees F (with temperatures ranging from 24 to 56 degrees F). Of the 17 times the refrigerator was out of range there was documentation 13 times out of the 17 opportunities the refrigerator temperature had been "adjusted", however, there was no follow up temperature recorded. RN-B stated the temperature of the medication refrigerator was not consistently in the acceptable range. The manufacturer's instructions for Lantus insulin pens dated May 2019, indicated unopened insulin pens should be stored in the refrigerator (36 to 46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Levemir insulin pens dated January 2019, indicated unopened insulin pens should be stored in the	01880		

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01880	Continued From page 33 refrigerator between 36 to 46 degrees F. Do not freeze. The manufacturer's instructions for Ozempic pens dated October 2022, indicated prior to first use, the pen should be stored in the refrigerator between 36 to 46 degrees F. Do not use if it has been frozen. The manufacturer's instructions for latanoprost eye drops dated, September 2020, indicated the unopened bottles should be stored in the refrigerator between 36 to 46 degrees F. The licensee's Medication Refrigerator/Freezer Monitoring policy dated April 2022, noted 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. SECURITY OF MEDICATIONS On May 22, 2023, at approximately 12:30 p.m., the surveyor observed licensed practical nurse (LPN)-D remove a Novolog (rapid-acting) insulin pen two (2) alcohol pads, and one (1) needle in sealed packaging from the A-B-C-D medication cart which was positioned against a hallway wall in an occupied open dining area and place them on the top of the unlocked A-B-C-D medication cart. LPN-D left the insulin pen and supplies on top of the unlocked medication cart and walked to the open kitchen area which was located behind her to get a pair of gloves which were positioned near a sink. On May 22, 2023, at 12:39 p.m., LPN-D said it was "ok" to leave medications on cart when they were in eye view. LPN-D stated she turned her back on the medication cart to get gloves, which	01880		

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01880	Continued From page 34 were "normally" in the medication cart. LPN-D stated she should have locked the medication cart when she left the medication cart to get the gloves which were located across the room near a sink adding she was nervous. On May 22, 2023, at 2:13 p.m., CNS-C stated medication should not be left unattended and the medication cart was to be locked when not in use. On May 23, 2023, at 4:03 p.m., the surveyor observed the A-B-C-D medication cart positioned on a wall, near the nurse's office, unlocked. The surveyor did not observe any staff near the medication cart or within eye view of the medication cart. On May 23, 2023, at approximately 4:05 p.m., regional nurse director (RND)-H locked the A-B-C-D medication cart. RND-H and CNS-C stated the medication cart should "always" be locked when not in use. The licensee's undated Medication Storage policy noted when medications managed outside of a resident's private "living space" must be in a securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup. Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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	30631	A. BUILDING: _____ B. WING _____	05/24/2023

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01890	Continued From page 35	01890		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for six of eight residents (R2, R4, R5, R6, R3, R7) and failed to monitor for expired stock medications. 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 22, 2023, at 10:48 a.m., the surveyor toured the facility with clinical nurse supervisor (CNS)-C and registered nurse (RN)-B, including a review of the locked medication carts and medication room. CNS-C observed and confirmed the following: TIME SENSATIVE MEDICATIONS	01890		

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	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 36 R2's two (2) opened Lantus 100 units/milliliter (ml) insulin pens (a multiple dose pen shaped injector device for insulin administration) did not have a label which indicated the date the pens had been opened and when the pens would expire. R4's opened Novolog 100 units/ml and Lantus 100 units/ml insulin pens did not have a label which indicated the date the pens had been opened and when the pens would expire. R5's opened toujeo 300 units/ml insulin pen did not have a label which indicated the date the pen had been opened and when the pen would expire. R6's opened bottle of latanoprost 0.005% ophthalmic solution (glaucoma medication) did not have a label which indicated the date the bottle of latanoprost had been opened and when the bottle of solution would expire. On May 22, 2023, at 10:52 a.m., CNS-C stated all insulin and eye drop solutions should be dated when opened. ORIGINAL PRESCRIPTION LABEL R3's twelve (12) unlabeled preset 0.1 ml syringes were in a clear plastic baggie with the following information handwritten with black marker on the outside of the plastic baggie, "[R3's first name and initial of last name] prn [as needed] syringes." This preset medication lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's full name, and the pharmacy in which it had been issued. R7's seven (7) unlabeled preset 0.1 ml syringes	01890		

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	30631	A. BUILDING: _____ B. WING _____	05/24/2023

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01890	Continued From page 37 were in a clear plastic baggie with the following information handwritten with black marker on the outside of the plastic baggie, "[R7's first name and initial of last name] morphine concentrate 2 mg [milligrams] (0.1 ml) every 1 [one] hr [hour] prn pain/dyspnea (shortness of breath)." This preset medication lacked an original prescription label with information regarding resident's full name and the pharmacy in which it had been issued. R7's one (1) unlabeled preset 0.2 ml syringe was in a clear plastic baggie with the following information handwritten with black marker on the outside of the plastic baggie, "[R7's first name and last name] 4 mg 7 a.m. dose". This present medication lacked an original prescription label with information regarding medication name and the pharmacy in which it had been issued. On May 22, 2023, at 11:05 a.m., CNS-C stated the above noted preset medications were not labeled with all the required content. EXPIRED MEDICATION In the locked medication room, the following stock medications were found to be expired: - one opened bottle of acetaminophen 500 mg expired April 2023 - one opened box containing 11 bisacodyl suppositories (laxative) expired February 2023 On May 22, 2023, at 11:23 a.m., RN-B stated the medication carts were checked weekly for expired medications, however the stock medications were not on a schedule to be checked. RN-B stated the staff were supposed to check the expiration date prior to administering the medication.	01890		

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	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01890	Continued From page 38 The manufacturer's instructions for Lantus insulin pens dated May 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Novolog insulin pens dated October 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for toujeo insulin pens dated February 2015, directed to discard the pen 28 days after it had been opened. The manufacturer's instructions for latanoprost eye drop solution dated September 2020, directed for the eye drop solution to be discarded six weeks after it had been opened. The licensee's undated Medication Disposal policy noted expired medications would be disposed of according to the accepted practices of the Minnesota board of Pharmacy and the labels from the containers will be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=F	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	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(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 39 disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (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 (R1) 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 22, 2023, at approximately 9:50 a.m., clinical nursing supervisor (CNS)-C stated the licensee provided medication management services to the residents at the facility.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(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 40 R1's diagnosis included memory problems, fatigue, and rheumatoid arthritis (autoimmune disease/inflammatory disorder affecting joints). R1's service plan was not available. R1's medication assessment dated December 2, 2021, noted R1 needed help with taking medication, medication administration. R1's master care plan dated January 27, 2023, noted R1 needed help taking medications, all medications to be administered by facility medication passers per provider order and registered nurse (RN) delegation. R1's " notes" included the following: - January 1, 2023, resident was taken by EMS (emergency medical service) to ER (emergency room) for evaluation - January 25, 2023, R1 receiving total assist of one (1) for transfers and cares. Skilled care recommended and it was decided to keep R1 at skilled care and give up R1's apartment. R1's provider's orders dated December 1, 2021, indicated R1 received the following medications; -vitamin D, 25 micrograms (mcg) daily -donepenzill 10 milligrams (mg) (memory) daily -finasteride 5 mg (urinary frequency) daily -folic acid 1 mg (supplement) daily -immodium 2 mg, give half tablet (loose stool) daily -latanoprost 0.005% eye solution 1 drop both eyes (dry eye/eye pressure) daily -methotrexate 2.5 mg give three (3) tablets (rheumatoid arthritis) daily -tamsulosin 0.4 mg (enlarged prostate) daily.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(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 41 R1's Discharge-Transfer Summary, noted discharge date January 27, 2023, authenticated by registered nurse (RN)-B February 1, 2023, noted discharge reason as hospitalization and noted the following medications; -anti-diarrheal 2 mg, give half tablet daily -donepezil 10 mg daily -finasteride 5 mg daily -folic acid 1 mg daily -latanoprost 0.005% daily -methotrexate 2.5 mg give three (3) daily -tamsulosin 0.4 mg daily -vitamin D3 25 mcg daily. R1's Current Medications at Discharge undated form noted all of the above-named medications, strength/dosages, route, and prescription number. R1's record did not include documentation of the quantity "sent" (disposed). On May 23, 2023, at 11:22 a.m., registered nurse (RN)-B stated medication counts for destroyed medications were only completed for narcotic medication, adding that is how she completes them. RN-B said R1's record lacked required content for the disposition of medications. The licensee's undated Medication Disposal policy noted 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 the staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(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 42 days	01910		
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:	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(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
02040	Continued From page 43 A record review and interview were conducted on May 22, 2023, at approximately 1:00 p.m. with Licensed Assisted Living Director (LALD)-A on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-A stated that a hazard vulnerability assessment for the emergency disaster plan for the facility had been conducted, but a hazard vulnerability assessment of the physical environment with mitigation factors on and around the property had not been completed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02170 SS=D	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.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD EGF SENIOR LIVING	608 5TH AVENUE NW EAST GRAND FORKS, MN 56721

(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
02170	Continued From page 44 (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not 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 interview and record review, the licensee failed to have a comprehensive evaluation for an activity plan for one of three residents (R2) who received services under an assisted living with dementia care license. 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: The facility currently held an Assisted Living with	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	05/24/2023

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02170	Continued From page 45 Dementia Care license. R2's diagnoses included Alzheimer's disease, congestive heart failure (CHF-a condition in which the heart's function as a pump is inadequate to meet the body's needs), hypertension (HTN- high blood pressure), and asthma. R2 had been admitted for services on April 26, 2023. R2's Individualized Activity Plan dated May 12, 2023, did not include the following: - past and current interests; - current abilities and skills; - motional and social needs and patterns; - adaptations necessary for the resident to participate; and - identification of activities for behavioral interventions In addition, R2's record lacked the development of an individualized activity plan. On May 23, 2023, at 1:02 p.m., clinical nurse supervisor (CNS)-C stated life enrichment coordinator (LEC)-I completes the activity evaluation and activity plan for the residents. CNS-C stated the activity evaluation and plan was usually completed upon admission. CNS-C stated an activity questionnaire had been sent to R2's family, however, the family had not returned the questionnaire back to the family yet. The licensee's Enrichment Programs, Activities and Outdoor Space policy dated January 2022, noted a Life History and Memorable Moments form would be completed for each resident upon admission. Life Enrichment staff visit with resident and/or family to complete this form.	02170		

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	30631	A. BUILDING: _____ B. WING _____	05/24/2023

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02170	Continued From page 46 Each resident must be evaluated for activities according to the licensing rules of the community, in addition, the evaluation must address the following: - past and current activities - current abilities and skills - emotional and social needs and patterns - physical abilities and limitations - adaptations necessary for the resident to participate, and - identification of activities for behavioral interventions An individualized activity plan must be developed for each resident based on their activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02170		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation and interview the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for storage of cleaning supplies. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 47 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: On May 22, 2023, at approximately 9:25, a.m., licensed assisted living director (LALD)-A stated all facility bathrooms were locked, required a key. On May 23, 2023, at 6:59 a.m., the surveyor observed the bathroom door on unit C open. Located on an open shelf was an opened bottle of Peroxide Multi Cleaner and Disinfectant. On May 23, 2023, at 7:03 a.m., registered nurse (RN)-B said the bathroom doors were to be locked at all times. RN-B stated cleaning chemicals should be "locked up." On May 24, 2023, at 8:44 a.m., the surveyor observed the bathroom door on unit C open. Located on an open shelf was an opened bottle of Peroxide Multi Cleaner and Disinfectant. On May 24, 2023, at 8:49 a.m., the surveyor observed the bathroom door on unit A was unlocked and a housecleaning cart was in the bathroom which contained: -a used spray bottle of Peroxide Multi Cleaner and Disinfectant -a used spray bottle of Crystal Spotter (carpet cleaner) -an unlabeled used spray bottle of a blue liquid -two (2) spray cans of OdoBan.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 48 Directly following the above observation clinical nurse supervisor (CNS)-C locked unit A's bathroom door. CNS-C stated bathroom doors were to be locked at all times. On May 24, 2023, at approximately 8:55 a.m., regional nurse director (RND)-H referred the surveyor to maintenance (M)-E regarding the unlocked chemicals. M-E stated he did not use Crystal Spotter and named a product used. M-E said he "thought" the blue liquid may be laundry detergent. On May 24, 2023, at 8:57 a.m., RND-H stated all chemicals should be labeled and all bathroom doors were to be locked. The Safety Data Sheet for Peroxide Multi Surface Cleaner and Disinfectant dated February 11, 2021, noted danger, harmful if swallowed or in contact with skin. Causes severe skin burns and eye damage. May cause an allergic skin reaction. Toxic if inhaled. Avoid breathing dust/fume/ gas/mist/vapors/spray. Wash skin thoroughly after handling. Do not eat, drink or smoke when using this product. Use only outdoors or in a well-ventilated area. Contaminated work clothing must not be allowed out of the workplace. Wear protective gloves/protective clothing/eye protection/ face protection. Storage: store in a well-ventilated place. Keep container tightly closed. Store locked up. The Safety Data Sheet for Crystal Spotter dated May 8, 2014, noted hazard identification, not classified. Expected to be a low hazard for usual industrial or commercial handling by trained personnel. The Safety Data Sheet for OdoBan dated	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30631	A. BUILDING: _____ B. WING _____	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 49 February 10, 2022, noted warning, may cause respiratory irritation, causes serious eye irritation. Wear eye and face protection. Wash exposed body parts thoroughly after handling. If in eyes; Rinse cautiously with water for several minutes. Remove contact lenses. If present and easy to do. Continue rinsing. Call a poison control center if you feel unwell. Store in a cool, dry ventilated area. Do not contaminate food, feed, or drinking water. Store away from strong oxidizers. The licensee's undated Safe Chemical Storage policy noted when chemicals must be used, proper storage and handling can reduce or eliminate associated risks. In addition, all chemicals should be labeled and dated upon receipt and on opening. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55165-0975
651-201-4500

Type: Full
Date: *05/22/23*
Time: 11:15:44
Report: 8046231051

Food and Beverage Establishment Inspection Report

Location:
Edgewood Egf Senior Living
608 5th Avenue Nw
East Grand Forks, MN56721
Polk County, 60

Establishment Info:
ID #: 0038265
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2187736648
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.

OBSERVED NO DEVICE OR STRIPS FOR DISH CONTACT TEMPERATURE. STRIPS WILL BE OBTAINED.

Comply By: 05/26/23

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

OBSERVED WIPING CLOTH BUCKET SANTIZER LOW. ESTABLISHMENT WILL USE CHLORINE UNTIL SANI DISPENSER IS REPAIRED.

Comply By: 05/22/23

4-500 Equipment Maintenance and Operation

4-501.11AB

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

OBSERVED DOOR HANDLES ON REACH IN FRIDGE BROKEN.

Comply By: 07/10/23

Type: Full
Date: *05/22/23*
Time: 11:15:44
Report: 8046231051
Edgewood Egf Senior Living

Food and Beverage Establishment Inspection Report

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

OBSERVED RESIDUE UNDER SINK AREA. ESTABLISHMENT WILL CLEAN.

Comply By: 05/25/23

Surface and Equipment Sanitizers

Acid: = 0 at Degrees Fahrenheit
Location:
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: 2 DOOR IN KICHEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: 36 Degrees Fahrenheit - Location: 1 DOOR IN STORAGE ROOM
Violation Issued: No

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

NO FOOD SERVICE AT TIME OF INSPECTION. FOOD IS BEING CATERED IN FROM HUGO'S FOR LUNCH, PIZZA DELIVERY FOR DINNER.

DISCUSSED WITH LUKE: CURRENT FOOD MANAGER IS LEAVING, NEED TO HIRE A NEW EMPLOYEE WITH A CERTIFIED FOOD PROTECTION MANGER, OR HAVE A NEW EMPLOYEE OBTAIN A CFPM CARD WITHIN 60 DAYS.

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 8046231051 of 05/22/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
LUKE KNAUF
EXECUTIVE DIRECTOR

Signed: Zach Johnson
Zachary Johnson R.S.
Public Health Sanitarian
Bemidji
218-308-2108
zach.johnson@state.mn.us

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55165-0975
651-201-4500

Type: Full
Date: *06/29/23*
Time: 11:44:02
Report: 8046231082

Food and Beverage Establishment Inspection Report

Location:
Edgewood Egf Senior Living
608 5th Avenue Nw
East Grand Forks, MN56721
Polk County, 60

Establishment Info:
ID #: 0038265
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2187736648
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Acid: = 272/403 at Degrees Fahrenheit
Location: wiping cloth bucket
Violation Issued: No

Hot Water: = at 184 Degrees Fahrenheit
Location: dish manifold
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: reach in fridge
Violation Issued: No

Process/Item: Cooking
Temperature: 170 Degrees Fahrenheit - Location: peas on stove
Violation Issued: No

Process/Item: Re-Heating
Temperature: 156 Degrees Fahrenheit - Location: Ham
Violation Issued: No

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

DAN HORSKI STARTED 6/28 AS FOOD SERVICE DIRECTOR. DAN WILL BE GETTING HIS STATE ISSUED CERTIFIED FOOD MANAGER CERTIFICATE AND NEXT AVAILABLE CLASS IN THIEF RIVER FALLS (LIKELY) OR ONLINE.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8046231082 of 06/29/23.

Certified Food Protection Manager: Dan Horski

Certification Number: pending Expires: / /

Signed: _____

Luke Knauf
Director

Signed: Zach Johnson

Zachary Johnson R.S.
Public Health Sanitarian
Bemidji
218-308-2108
zach.johnson@state.mn.us