



STATE LICENSING COMPLIANCE REPORT

Report #: HL30824001C

Date Concluded: October 7, 2021

Name, Address, and County of Facility

Investigated:

Edgewood Hermantown I Sr Living
4195 Westburg Road
Hermantown MN 55811
Saint Louis County

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

Evaluator's Name: Angela Vatalaro, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD DULUTH, MN 55811			
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0 000	Initial Comments Initial comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL30824015 On October 4, 2021, through October 7, 2021, surveyors of this Department's staff, visited the above provider and the following correction orders were issued. At the time of the survey, there were 174 clients that were receiving services under the Assisted Living/Dementia Care license. In addition, MDH investigated complaint HL30824001C. There was no licensing order issued related to HL30824001C.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. 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		
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a	0 250			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 250	Continued From page 1 result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner;	0 250		

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0 250	Continued From page 2 (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure by attesting the managerial officials who were in charge of the day-to-day operations developed and implemented current policies and procedures as required with records reviewed. This had the potential to affect all 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on October 4, 2021, at approximately 10:30 a.m., licensed assisted living director (LALD)-B and Registered Nurse (RN)-B stated they were somewhat familiar with the Assisted Living with Dementia Care statutes.	0 250			

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0 250	Continued From page 3 The licensee's "Application for Assisted Living License," section titled, "Official Verification of Owner or Authorized Agent" (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 , my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 - I have read and fully understand Minn. Stat. sect. 144G.80 144G.81 and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 , my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) . - Reporting of Maltreatment of Vulnerable Adults - Electronic Monitoring in Certain Facilities . - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. Chapter 144G and Minnesota Rules, chapter 4659 (proposed and not final) governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence f a management agreement or subcontract."	0 250			

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0 250	Continued From page 4 - "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 (proposed and not final) in place upon licensure and to keep them current as applicable." Page five was electronically signed by the owner on May 10, 2021. The licensee failed to ensure the following policies and procedures were in place and kept current: - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; - orientation to and implementation of the assisted living bill of rights; - infection control practices;	0 250		

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0 250	Continued From page 5 - conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; - medication and treatment management. Refer to licensing order at Statute 144G.41, Subd. 3. The licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19. Refer to licensing order at Statute 144G.41, Subd. 7. The licensee failed to post in a conspicuous place, information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This had the potential to affect all 174 residents receiving assisted living services. Refer to licensing order at Statute 144G.42, Subd. 7. The licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living	0 250			

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0 250	Continued From page 6 facility. Refer to licensing order at Statute 144G.42, Subd. 9. The licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to complete a TB Risk assessment every two years. Additionally, the licensee failed to ensure history and symptoms screenings were completed and documented for three of five employees unlicensed personal (ULP)-J, ULP-K, and ULP-I with employee records reviewed. Refer to licensing order at Statute 144G.63, Subd. 2. The licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations for five of six employees ULP-F, ULP-I, ULP-J, and ULP-K with records reviewed. Refer to licensing order at Statute 144G.70, Subd. 2. The licensee failed to ensure the registered nurse (RN) completed a comprehensive re-assessment following a change of condition for two of six residents (R3 and R4) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 3. The licensee failed to reassess the resident's medication management services when the medication related issues were identified for one of one resident (R9) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 5. The licensee failed to ensure individual medication management plans contain all the required content for two of eight residents (R3	0 250			

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0 250	Continued From page 7 and R4) with records reviewed. Refer to licensing order at Statute 144G.71, Subd. 7. The licensee failed to ensure one of four ULP-I followed written protocols pertaining to insulin pens, eye drops, and . nebulizers. In addition, the licensee failed to ensure written instructions pertaining to insulin pens, eye drops, and nebulizers were in two of six resident (R1 and R2) records with records reviewed. Refer to licensing order at Statute 144G.71, Subd.8. The licensee failed to ensure medications were documented after administration for one of six residents (R2), failed to ensure medications were administered as ordered for three of six residents (R4, R9 and R10), and failed to ensure the effectiveness of as needed (PRN) medications were documented in one of six residents (R10) with records reviewed. Refer to licensing order at Statute 144G.72, Subd.3. The licensee failed to develop a treatment management plan to include all required content for one of six residents (R4) with oxygen. Refer to licensing order at Statute 144G.72, Subd. 4. The licensee failed to ensure the RN specified, in writing, specific instructions for one of six residents (R4) receiving treatment management services. Refer to licensing order at Statute 144G.72, Subd. 5. The licensee failed to document treatments for one of six residents (R3) with records reviewed. Thirty-Nine (39) correction orders were issued, which indicated the licensee's understanding of	0 250			

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0 250	Continued From page 8 the Minnesota statutes were limited or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 430 SS=F	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the uniform checklist of disclosure of service included the required content was provided to four of four residents	0 430		

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0 430	Continued From page 9 (R5, R6, R1, and R2) and failed to ensure two of six residents (R3 and R4) received the uniform checklist of disclosure services. This had the potential to affect all 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The uniform checklist of disclosure of services provided to R5, R6, R1, and R2 did not include the disclosure of the categories of assisted living licenses available and the category of license held by the facility. R5 R5's diagnoses included, but were not limited to, Myasthenia Gravis (a weakness and rapid fatigue of muscles under voluntary control). R5's service plan dated September 23, 2021, indicated R5 received services which included medication administration and shower assistance. On October 5, 2021, at approximately 7:30 a.m., unlicensed personnel (ULP)-G was observed administering R5 his scheduled morning medications. R6 R6's diagnoses included, but were not limited to,	0 430			

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0 430	Continued From page 10 heart failure. R6's service plan dated September 3, 2021, indicated R6 received services which included medication administration, showers, dressing, and transfer assistance. On October 5, 2021, at approximately 7:00 a.m., ULP-F was observed administering R6 his scheduled morning medications. R1 R1's diagnoses included, but were not limited to, type II diabetes, obesity, and hypertension. R1's signed service plan dated April 8, 2021, indicated R1 received services which included medication administration, blood glucose monitoring, and shower assistance. On October 5, 2021, at approximately 6:30 a.m., ULP-I was observed administering medication to R1 and checking R1's blood glucose. R2 R2's diagnoses included, but were not limited to, lung cancer. R2's service plan dated September 16, 2021, indicated R2 received services which included medication administration, blood glucose monitoring, nebulizer treatments, dressing, grooming, toileting, and transfer assistance. On October 5, 2021, at approximately 6:55 a.m., ULP-I was observed administering oral medications and a nebulizer treatment to R2 and checked R2's blood glucose. On October 6, 2021, at approximately 10:00	0 430		

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STREET ADDRESS, CITY, STATE, ZIP CODE

EDGEWOOD HERMANTOWN I SR LVG

**4195 WESTBERG ROAD
DULUTH, MN 55811**

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0 430	Continued From page 11 a.m., licensed assisted living director (LALD)-A confirmed R5, R6, R1, R2, and all other residents receiving services under the facility's license had not received a disclosure of the categories of assisted living licenses available and the category of license held by the facility. R3 and R4's records lacked evidence they received a uniform checklist disclosure of services. R3 R3's diagnoses included, but were not limited to, dementia R3's service agreement dated November 22, 2020, indicated the resident received services which included medication administration, dressing, hygiene, toileting, catheter care, bathing, anticoagulation, housekeeping and laundry assistance. On October 5, 2021, at approximately 7:23 a.m., Licensed Practical Nurse (LPN)-V was observed assisting R3 with ambulation, hearing aide placement and eyeglasses R4 R4's diagnoses included, but were not limited to, vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), diabetes mellitus II (results from insufficient production of insulin, causing high blood sugar), and hypertension (high blood pressure). R4's service agreement dated July 1, 2021, indicated the resident received services which included medication administration, wound care, and assistance with bathing, dressing, grooming,	0 430		

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0 430	Continued From page 12 toileting and safety checks. On October 5, 2021, at approximately 7:50 a.m., LPN-V was observed assisting R4 with dressing, grooming, a brief change and peri-care. On October 6, 2021, at approximately 10:00 a.m., LALD-A confirmed R3 and R4 had not received a uniform checklist disclosure of services. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430			
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living	0 460			

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0 460	Continued From page 13 facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a means for two of two residents residing in memory care (R3 and R4) to request assistance for health and safety needs as required. The licensee did not have a system in place in memory care for residents at the facility to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all 34 residents residing in memory care (The Lodge) at 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 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: During the entrance conference on October 4, 2021, at approximately 10:50 a.m., Registered Nurse (RN)-B and licensed assisted living director (LALD)-A confirmed the facility had a separate memory care unit that was detached from the main building (4195) that did not have a call system for residents to request assistance. R3 R3's diagnoses included, but were not limited to, vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part	0 460		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
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0 460	Continued From page 14 of the brain), hypertension (high blood pressure), macular degeneration (vision impairment resulting from deterioration of the central part of retina), and focal, partial symptomatic epilepsy with simple partial seizures (when the seizure begins in one side of the brain and the person has a change in their level of awareness during some or all of it). R3 resided in secure unit 6B. On October 5, 2021, at approximately 7:23 a.m., R3 was observed dressed and ambulating in his room from the bathroom to the main area. R3 was noted not to have a call pendant or any other device on his person or in his room to call staff for assistance, if needed. R4 R4's diagnoses included, but were not limited to, vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), diabetes mellitus II (metabolic disorder in which the body has high sugar levels for prolonged periods of time), dysphagia (difficulty in swallowing), rhabdomyolysis (muscle injury where the muscles break down), and seizures (sudden, uncontrolled electrical disturbance in the brain which can cause changes in behavior, movements, feelings, and consciousness). R4 resided in secure unit 7A. On October 5, 2021, at approximately 7:10 a.m., R4 was observed being assisted by staff with a brief change, grooming and dressing. R4 was noted not to have a call pendant in her room, on her person or any other device available to call staff for assistance, if needed. On September 7, 2021, at approximately 9:45	0 460			

Minnesota Department of Health

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0 460	Continued From page 15 a.m., RN-B confirmed a system for residents to access staff 24 hours a day, seven days a week to request assistance for health and safety needs was not in place. RN-B confirmed assessments had not been completed to determine the cognitive level of residents residing in the secure memory care unit for use of a call pendant and stated, "We've looked at cow bells being an option for the cognitive residents, but there are just no one using them now." Licensees policy titled, Admission and Discharge, dated August, 2020, indicated memory care residents are observed every 30 minutes for safety. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week,	0 470			

Minnesota Department of Health

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0 470	Continued From page 16 who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required staffing plan was developed and posted. This had the potential to affect all residents in the assisted living facility, staff and any visitors of the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and	0 470		

Minnesota Department of Health

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0 470	Continued From page 17 - be posted after redacting direct-care staff member's resident assignments at the beginning of each work shift in a central location in each building. On October 4, 2021, at approximately 10:30 a.m., Registered Nurse (RN)-B confirmed a staffing plan had not been developed or a schedule posted as required. On October 4, 2021, at approximately 1:45 p.m. during the tour of the facility, all units in the assisted living building and the memory care building lacked a posting of daily staffing scheduled. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) 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: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	0 480		

Minnesota Department of Health

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0 480	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports dated October 5, 2021. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as	0 510		

Minnesota Department of Health

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0 510	Continued From page 19 applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control and current recommendations for COVID-19. This had the potential to affect all residents and staff. 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: Resident Screening The facility failed to ensure residents were screened for COVID-19. The Minnesota Department of Health (MDH) guidance titled, "COVID-19 Toolkit," dated March 8, 2021, indicated all residents should be actively screened for fever and respiratory symptoms at least daily. Daily pulse oximeter screening was recommended. Chart all clinical measurements and symptoms for each resident. On October 5, 2021, at approximately 8:27 a.m.,	0 510		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

EDGEWOOD HERMANTOWN I SR LVG

**4195 WESTBERG ROAD
DULUTH, MN 55811**

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0 510	Continued From page 20 unlicensed personnel (ULP)-K was asked where documentation was kept and how COVID-19 screening for residents was conducted in the memory care units. ULP-K stated, " No daily screening is done. If there's a symptom, we would tell the nurse." On October 5, 2021, at approximately 2:00 p.m., COVID-19 screening documentation was requested from licensed assisted living director (LALD)-A for the detached memory care units. On October 5, 2021, at approximately 2:30 p.m., LALD-A stated, "There are no screening logs available for memory care; they haven't done any." The licensee's COVID-19 Infection Prevention policy last revised August 10, 2021, indicated all residents in the community will have their temperature and oxygen saturation monitored daily. Employee Screening The facility failed to ensure employees followed employee COVID-19 screening procedures. On October 5, 2021, at approximately 5:53 a.m., a staff person arrived at the main entrance of the assisted living building, proceeded to the reception desk in the main entrance, took their temperature with a thermometer that was sitting on the desk, and signed the employee screening sheet. The staff person set the thermometer on the desk after using, without cleaning, the thermometer. The surveyor was waiting at the desk to be screened. Registered Nurse (RN)-B arrived and with the same thermometer took the surveyor's temperature. RN-B set the	0 510		

Minnesota Department of Health

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0 510	Continued From page 21 thermometer on the desk without cleaning the thermometer. Another staff person coming on duty picked up the same thermometer and took their temperature. There were no supplies on the desk to clean the thermometer. RN-B confirmed the thermometer was not cleaned in between uses and that there was no cleaning supplies on the desk. RN-B got disinfectant wipes and cleaned the thermometer and left the wipes on the desk. RN-B stated the thermometer should be cleaned in between uses. On October 5, 2021, at approximately 7:52 a.m., the beautician (B)-A was observed to walk in door 11, the outside door in the back dining room of the main building.. B-A did not screen herself at the door, was not wearing a face mask or eye protection, and walked down the hallway to the beauty shop. At 8:15 a.m., B-A was observed washing a resident's hair in the beauty shop. B-A was not wearing a face mask or eye protection. At approximately 8:20 a.m., licensed assisted living director (LALD)-A confirmed B-A had not been screened for COVID-19, and B-A was not wearing a face mask or eye protection while washing a resident's hair. The licensee's COVID-19 Infection Prevention policy last reviewed August 10, 2020, indicated staff would complete hand hygiene upon entrance to the community. Staff would have a temperature taken, would be screened for current signs and symptoms of cough, shortness of breath, fever, or any other signs of illness. The policy did not address cleaning the thermometer in between uses. Personal Protective Equipment The facility failed to ensure staff wore personal	0 510			

Minnesota Department of Health

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0 510	Continued From page 22 protective equipment (PPE) per CDC and the MDH guidelines. The MDH COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated June 30, 2021, instructed health care workers (HCW) with face-to-face contact with COVID-19 negative residents to wear a medical grade well fitting facemask and eye protection. The MDH Infection Prevention and Control: COVID-19 Electronic Guidance for Infection Prevention and Control in Health Care Settings, dated August 2, 2021, indicated MDH recommends eye protection for all health care workers (HCW) in all resident care areas and when providing direct care. On October 4, 2021, at approximately 1:40 p.m., housekeeper (H)-Q was observed sitting at the reception desk in the lobby. H-Q wore a facemask and did not have on eye protection while she spoke with a resident. On October 4, 2021, at approximately 1:50 p.m., unlicensed personnel (ULP)-G was observed at a medication cart; ULP-G wore a facemask and did not have on eye protection. On October 4, 2021, at approximately 1:50 p.m., ULP-G wore her facemask below her nose as she spoke to the surveyor. She said her facemask kept falling. She stated she passed medications to residents. When asked if she wore eye protection, ULP-G retrieved eye protection hanging off her scrub top uniform and put eye protection on. On October 4, 2021, at approximately 2:00 p.m.,	0 510		

Minnesota Department of Health

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0 510	Continued From page 23 22 residents were observed participating in a worship and communion activity located in the chapel. One resident wore a cloth face covering, 21 residents did not have on facemasks. On October 4, 2021, at approximately 2:10 p.m., two ULPs were observed at a medication cart in a hallway. Both ULPs wore facemasks; ULP-L did not have on eye protection. On October 4, 2021, at approximately 2:10 p.m., ULP-L stated she did not need to wear eye protection because she wore eyeglasses. On October 4, 2021, at approximately 2:10 p.m., Registered Nurse (RN)-B stated all staff had received eye protection, and the facility had eye protection available for staff use. On October 4, 2021, at approximately 2:15 p.m., upon entrance into the memory care dining room, Licensed Practical Nurse (LPN)-M was observed at a medication cart wearing a facemask and did not have on eye protection. In the dining room, two residents were observed playing cards at a table. A third resident sat at another table, and a fourth resident sat at a different table. All residents did not have on facemasks. Upon surveyors' approach, LPN-M put on eye protection. On October 4, 2021, at approximately 2:15 p.m., LPN-M verified he did not have on eye protection and stated he was supposed to wear eye protection. On October 4, 2021, at approximately 2:20 p.m. in the memory care, housekeeper (H)-N wore a cloth face covering.	0 510			

Minnesota Department of Health

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0 510	Continued From page 24 On October 4, 2021, at approximately 2:20 p.m., H-N stated it did not matter if she wore a cloth face covering or medical grade facemask. RN-B instructed H-N to put on a medical grade facemask. On October 4, 2021, at approximately 2:20 p.m., the memory care building was divided into three separate living areas identified as PODS, which included POD A, POD B, and POD C. During an observation on October 4, 2021, at approximately 2:25 p.m., ULP-O walked past residents through POD A, POD B, and POD C, to a medication cart located in POD C. ULP-O wore a facemask and did not have on eye protection. On October 4, 2021, at approximately 2:25 p.m., ULP-O verified she was not wearing eye protection and said she was supposed to wear eye protection. On October 4, 2021, at approximately 2:25 p.m. ULP-P was observed only wearing a facemask and did not have on eye protection. On October 4, 2021, at approximately 2:25 p.m., ULP-P stated he passed medications and provided direct care. ULP-P said he misplaced his eye protection and verified he wore a cloth face covering. On October 4, 2021, at approximately 2:30 p.m. in memory care, ULP-K was observed wearing a cloth source face covering. On October 4, 2021, at approximately 2:30 p.m., ULP-K verified she was not wearing a medical grade facemask. She said her cloth face covering had four layers. She said she forgot her medical	0 510			

Minnesota Department of Health

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0 510	Continued From page 25 grade facemask at home. On October 4, 2021, at approximately 3:30 p.m., H-Q sat at the reception desk in the lobby. H-Q verified she worked at the reception desk during her shift on October 4, 2021. H-Q verified she did not wear eye protection when she spoke to residents at the desk. H-Q said she was instructed to wear eye protection; however, she did not have eye protection on during her shift. The licensee's COVID-19 Infection Prevention policy last revised August 10, 2020, indicated masks will be worn throughout the shift except when eating/drinking in a designated community break area or when leaving the building for a break. The policy does not address the need to wear eye protection. Hand Hygiene During Medication Administration R1 R1's diagnoses included, but were not limited to, type II diabetes, obesity, and hypertension. R1's signed service plan dated April 8, 2021, indicated R1 received services which included medication administration, blood glucose monitoring, and shower assistance. R1's Individualized Medication Management Plan dated September 19, 2021, indicated R1 received medication management services, including assistance with oral medications, eye drops, and injectable medications. R1's prescriber orders dated January 21, 2021, included, but not was not limited to, Tresiba 200, 200 unit/milliliters (ml) suspension; inject 50 units under the skin daily in the AM and sterile lubricant	0 510		

Minnesota Department of Health

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0 510	Continued From page 26 eye drops instill two drops in both eyes daily. On October 5, 2021, at approximately 6:20 a.m., unlicensed personnel (ULP)-I prepared medications for R1, which included oral medications, eye drops, and use of an insulin pen. ULP-I performed hand hygiene, removed, prepared, and placed R1's oral medications into a medication cup. ULP-I removed R1's Systane eyedrops (sterile lubricant), and R1's Tresiba insulin pen from the medication cart. ULP-I dialed up 50 units of Tresiba without priming the pen. ULP-I put a pair of gloves into her scrub uniform pocket along with R1's Systane eye drops and Tresiba insulin pen. ULP-I took R1's medication cup of oral medications, left the medication cart, and went to R1's apartment. In R1's apartment, ULP-I handed the medication cup of oral medications to R1. R1 swallowed pills followed by a drink of water. ULP-I removed R1's Systane eye drops from her pocket and instilled two drops into each eye, ULP-I did not perform hand hygiene, did not wear gloves and did not instill eye drops into the conjunctival sac of R1's eyes. ULP-I did not perform hand hygiene and put on her gloves and checked R1's blood glucose (pricked a finger with a lancet [device that has a small, sharp needle] and obtain a drop of blood.) Following R1's blood glucose check and insulin administration, ULP-I removed gloves, put on new gloves, discarded R1's insulin needle and lancet into sharps, removed gloves, and performed hand hygiene. R2 R2's diagnoses included, but were not limited to, lung cancer. R2's service plan dated September 16, 2021, indicated R2 received services which included	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG			STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD DULUTH, MN 55811		
(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
0 510	Continued From page 27 medication administration, blood glucose monitoring, nebulizer treatments, dressing, grooming, toileting, and transfer assistance. R2's Individualized Medication Management Plan, undated, indicated R2 received medication management services including assistance with oral medications and nebulizer treatment. R2's prescriber orders dated September 15, 2021, included, but was not limited to, orders for ipratropium albuterol 0.5- 2.5 milligrams (mg) nebulizer 3 milliliters (ml) into the lungs every six hours. On October 5, 2021, at approximately 6:45 a.m., ULP-I performed hand hygiene and prepared medications for R2, which included oral medications and nebulizer medication. ULP-I removed oral medications for R2 and put into a medication cup. ULP-I removed one ipratropium albuterol 0.5-2.5 mg 3 ml dose vial from the medication cart. ULP-I put a pair of gloves into her scrub uniform pocket, left the medication cart and took R1's medication cup of oral medications and one ipratropium albuterol 0.5-2.5 mg dose vial into R2's apartment. ULP-I handed the medication cup of oral medications to R2. R2 swallowed pills followed by a drink of water. ULP-I put on her gloves, checked R1's blood glucose (pricked a finger with a lancet [device that has a small, sharp needle] and obtain a drop of blood.) ULP-I did not remove gloves or perform hand hygiene after checking R2's blood glucose. Using the same gloved hands ULP-I added the ipratropium albuterol 0.5-2.5 mg dose vial into the nebulizer mouthpiece treatment reservoir. ULP-I told R2 the nebulizer treatment was all set for her to self-administer and told R2 she would be back in 20 minutes to check in. ULP-I removed gloves,	0 510			

Minnesota Department of Health

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0 510	Continued From page 28 returned to the medication cart and documented administration of R2's ipratropium albuterol 0.5-2.5 mg 3 ml dose. ULP-I performed hand hygiene. On October 6, 2021, at approximately 2:30 p.m., RN-B stated it was an expectation staff perform hand hygiene and wear gloves when administering eye drops. RN-B stated it was an expectation staff perform hand hygiene before putting on gloves and after removal of gloves. RN-B stated it was an expectation staff removed gloves and performed hand hygiene after checking blood glucose. RN-B stated the staff member should not have used the same gloves to check a blood glucose and afterwards set up a nebulizer treatment. A policy for hand washing was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
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0 550	Continued From page 29 information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post in a conspicuous place, information about the facility's grievance procedure and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 October 4, 2021, at approximately 1:30 p.m. during the facility wide tour, the surveyor observed the licensee lacked a posting of the grievance procedure, the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. There was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC).	0 550			

Minnesota Department of Health

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0 550	Continued From page 30 On October 4, 2021, at approximately 1:30 p.m., licensed assisted living director (LALD)-A confirmed the licensee had not posted the required postings of the grievance procedure and information related to reporting suspected maltreatment to MAARC. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
0 570 SS=F	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to display the current assisted living with dementia license at the main entrance of one of two assisted living buildings. 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:	0 570			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
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0 570	Continued From page 31 On October 4, 2021, at approximately 10:30 a.m., upon entering the facility, the current license was not observed to be posted at the facility entrance of the main assisted living building as required. On October 4, 2021, at approximately 1:30 p.m., licensed assisted living director (LALD)-A confirmed the license was not posted at the facility entrance in the assisted living building or the memory care building . The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size of the facility and relevant	0 580			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
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0 580	Continued From page 32 to the type of services provided. This had the potential to affect all 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 4, 2021, at approximately 10:30 a.m. during the entrance conference, licensed assisted living director(LALD)-A stated he was not aware of the need for quality management activities. The licensee's Quality Assurance policy dated August 2020 indicated each community will have at least one documented quality improvement project in place at all times and retain records of such projects for at least two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in	0 640		

Minnesota Department of Health

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0 640	Continued From page 33 common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 4, 2021, at approximately 1:30 p.m., during a tour of the main assisted living building that included common areas with telephones provided by the assisted living facility, it was observed that required posted information had not been posted. At approximately 2:20 p.m., during a tour of the memory care building that	0 640		

Minnesota Department of Health

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0 640	Continued From page 34 included common areas with telephones provided by the assisted living facility, it was observed that required posted information had not been posted. On October 4, 2021, at approximately 2:20 p.m., licensed assisted living director (LALD)-A confirmed the above required posted information was not posted in either the assisted living or memory care buildings. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision.	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
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0 660	Continued From page 35 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to complete a TB risk assessment every two years. In addition, the licensee failed to ensure history and symptom screenings were completed and documented for two of five unlicensed personnel ((ULP)-J, and ULP-K,) with employee records reviewed. 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). TB FACILITY RISK ASSESSMENT On October 4, 2021, at approximately 1:05 p.m., a facility TB risk assessment was requested and reviewed. The TB risk assessment provided by the licensed assisted living director (LALD)-A dated October 1, 2019, indicated low risk; however, the TB risk assessment had exceeded the two year cycle and was no longer valid. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013 and CDC guidelines indicated a TB infection control program should include a facility TB risk assessment.	0 660			

Minnesota Department of Health

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0 660	Continued From page 36 TB EMPLOYEE HISTORY AND SYMPTOM SCREENING ULP-K and ULP-J's employee records lacked evidence a TB history and symptom screening had been completed. ULP-K and ULP-J began providing assisted living services on August 1, 2021. On October 5, 2021, at approximately 6:30 a.m., ULP-K was observed providing a two-person transfer, grooming, peri-care and dressing assistance to resident (R)11. On October 5, 2021, at approximately 8:37 a.m., ULP-J was observed administering medications to R10. On October 6, 2021, at approximately 10:45 a.m., Registered Nurse (RN)-B confirmed ULP-K and ULP-J's TB history and symptom screenings had not been completed and were not in the employee files as required. The licensee's Tuberculosis policy dated August 2020 indicated the licensee would establish and maintain a TB infection control program, a TB risk assessment, a written infection control plan and screening of all employees. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
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0 680	Continued From page 37 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant 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 have a written emergency disaster plan that included all required content and failed to post an emergency plan prominently. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a	0 680		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
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0 680	Continued From page 38 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: During the entrance conference on October 4, 2021, at approximately 10:30 a.m., a request was made to view the licensee's emergency preparedness plan, which was provided and reviewed by the surveyor. On October 4, 2021, at approximately 1:30 p.m., during tour of the facility with licensed assisted living director (LALD)-A and Registered Nurse (RN)-B verified the required signage postings or information regarding the licensee's emergency plan was not posted in either the main assisted living building or the memory care builds main entrances or elsewhere in the facility. The licensee's emergency plan provided Emergency Preparedness/Disaster Plan, dated 2021, was a template for the development of the Emergency Preparedness/Disaster Plan and had not been completed. to contain the required content. On October 6, 2021, at approximately 10:00 a.m., LALD-A confirmed the licensee had not fully developed or implemented the facility's emergency preparedness plan. In addition, LALD-A confirmed staff were not familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] State Operations Manual which includes the emergency preparedness guidelines). No further information was provided.	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
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0 680	Continued From page 39	0 680		
0 690 SS=E	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure entries on safety check flow sheets were authenticated by the name and title of the person making the entry. This had the potential to affect all residents in the memory care unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 5, 2021, at approximately 8:27 a.m., staff were observed documenting into a log book that contained flow sheets used for 30 minutes safety checks. Unlicensed personnel (ULP)-K stated the flow sheets were used for the "whole building" referencing the secured memory care building.	0 690		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
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0 690	Continued From page 40 The flow sheets dated September 21, 2021, to October 4, 2021, indicated that licensee failed to assure that safety check flow sheets included authentication with the name and title of the person making the entry on 14 out of 14 days reviewed. On October 5, 2021, at approximately 2:30 p.m., licensed assisted living director (LALD)-A confirmed safety check flow sheets dated September 21, 2021 to October 4, 2021 failed to include an authentication with the name and title of the person that had made the entry. The licensee's Documentation policy dated August 2020, indicated every entry in a resident record would be legible, complete, dated and authenticated with the name, time and signature of the person making the entry. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 690		
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced	0 700		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG			STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD DULUTH, MN 55811		
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0 700	Continued From page 41 by: Based on observation, interview, and record review, the licensee failed to ensure unauthorized persons did not have access to resident records for one of two residents (R1) reviewed. 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: R1 R1's diagnoses included, but were not limited to, type II diabetes, obesity, and hypertension. R1's Individualized Medication Management Plan dated September 19, 2021, indicated R1 received medication management services, including assistance with oral medications, eye drops, and injectable medications. On October 5, 2021, at approximately 6:20 a.m., unlicensed personnel (ULP)-I prepared medications for R1, which included oral medications, eye drops, and use of an insulin pen . ULP-I used a tablet on the medication cart to view R1's medication administration record. ULP-I removed, prepared, and placed R1's oral medications into a medication cup. ULP-I removed R1's eyedrops, and R1's Tresiba insulin pen from the medication cart. ULP-I finished preparing R1's medications, left the medication cart, and walked down the hall to R1's apartment door. ULP-did not secure the tablet screen on the	0 700			

Minnesota Department of Health

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0 700	Continued From page 42 medication cart that displayed R1's electronic medication administration record. On October 5, 2021, at approximately 6:30 a.m., ULP-I verified R1's electronic medication administration record displayed on the tablet screen and verified she did not secure R1's medical record before leaving the medication cart. She verified anyone who walked by the medication cart would be able to see R1's record. ULP-I secured the tablet screen. On October 6, 2021, at approximately 2:30 p.m., Registered Nurse (RN)-B stated it was an expectation staff did not leave the medication cart tablet screen open and unsecure when they walked away. The licensee's policy titled, Documentation, dated August 2020 indicated all resident records are stored in a safe and secure manor. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history,	0 730			

Minnesota Department of Health

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0 730	Continued From page 43 allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document 30 minute safety checks in the resident record for two of two	0 730			

Minnesota Department of Health

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0 730	Continued From page 44 residents (R3 and R4) in memory care with records reviewed. 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: R3 and R4 records lacked documentation of services provided by staff. R3 R3's diagnoses included, but were not limited to, vascular dementia, (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), atrial fibrillation (an irregular often fast heart rate), and focal partial epilepsy (the seizure begins in one side of the brain and the person has no loss of awareness of their surroundings during it). R3's service agreement dated November 22, 2020, indicated R3 received services which included medication administration, dressing, hygiene, toileting, catheter care, bathing, anticoagulation, housekeeping and laundry assistance. R3's safety check flowsheet did not include documentation of completed 30-minute safety check services as follows: -September 24, 2021 - 2130, 2200	0 730		

Minnesota Department of Health

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0 730	Continued From page 45 -September 26, 2021 - 1430, 1500, 1530, 1600, 1630, 1700, 1730, 1800 -October 2, 2021 - 0400, 0430, 0500, 0530, 0600 R3's resident record did not include 30-minute safety check flowsheets for seven (7) out of 14 days as follows: - September 26, 29, 30, 2021; and - October 1, 2, 3, 4, 2021. On October 5, 2021, at approximately 7:23 a.m., licensed practical nurse (LPN)-V was observed assisting R3 with walker and ambulation, hearing aide placement and eyeglasses. R4 R4's diagnoses included, but were not limited to, vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), diabetes mellitus II (results from insufficient production of insulin, causing high blood sugar), hypertension (high blood pressure). R4's service agreement dated July 1, 2021, indicated R4 received services which included medication administration, wound care, bathing, dressing, grooming, toileting and safety checks. R4's resident record failed to include documentation for completion of 30-minute safety check services as follows: - September 21, 2021 - 1830, 1900, 1930, 2000, 2030, 2100, 2130, 2200, 2230, 2300, 2330, 2400, 0030, 0100, 0130, 0200, 0230, 0300, 0330, 0400,	0 730		

Minnesota Department of Health

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0 730	Continued From page 46 0430, 0500, 0530, 0600 - September 29, 2021 - 2130, 2200, 0600 - October 2, 2021 - 1630, 1700, 1730, 1800, 1830, 1900, 1930, 2000, 2030, 2100, 2130, 2200 - October 3, 2021 - 2130, 2200 On October 5, 2021, at approximately 7:50 a.m., LPN-V was observed assisting R4 with dressing, grooming, a brief change and peri-care. On October 7, 2021, at approximately 9:45 a.m., Registered Nurse (RN)-B confirmed safety check flowsheets had not been entered into resident records for R3 or R4. The licensee's Admission and Discharge policy dated August, 2020 indicated memory care residents were observed every 30 minutes for safety. The licensee's Documentation policy dated August 2020 indicated that the resident's record provided completed documentation of the services provided to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in	0 780			

Minnesota Department of Health

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0 780	Continued From page 47 the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain two smoke alarms in resident rooms. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or that a situation has occurred only occasionally) The findings include: On October 5, 2021, between 10:00 a.m. and	0 780		

Minnesota Department of Health

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0 780	Continued From page 48 2:30 p.m., survey staff toured the facility with the environmental services director (ESD)-E. On October 5, 2021, during the facility tour of main building 4195 between 10:00 a.m. and 1:30 p.m., the following observations were made: Shared resident room 211 - In one of the resident's bedrooms, the green power light on smoke alarm was not illuminated. Resident room 132 - The green power light was not illuminated on the smoke alarm installed outside the bedroom, and the battery compartment door was open and empty. When ESD-E put the smoke alarm back together, it started to chirp. On October 5, 2021, ESD-E confirmed both smoke alarms as noted above required maintenance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility	0 800			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

EDGEWOOD HERMANTOWN I SR LVG

**4195 WESTBERG ROAD
DULUTH, MN 55811**

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0 800	Continued From page 49 failed to maintain the physical environment in a continuous state of good repair and operation. This had the potential to directly affect all residents and staff. 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 the potential to affect a large portion or all of the residents). The findings include: On October 5, 2021, between 10:00 a.m. and 2:30 p.m., survey staff toured the facility with the environmental services director (ESD)-E. The following observations were made in the main building 4195: - Emergency lights did not work when tested in the hallway leading to the exit door of wing B in the main building or in the hall corridors near rooms 407, 434, or in the Rustic Room in the main building. - In back of the main building, a section of gutter was missing and several sections of gutter were warped near exit door 6. The missing and damaged sections of gutter created insufficient drainage away from the building. - On the back of main building, a section of gutter was missing and several sections of gutter were warped near exit door 6. The missing and damaged sections of gutter created insufficient drainage away from the building. - The make-up water line had a threaded hose connection with a hose attached in the 3rd fire sprinkler riser/mechanical room. During the	0 800		

Minnesota Department of Health

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0 800	Continued From page 50 facility tour, ESD-E was asked if this hose was used to directly connect to the boiler. He confirmed that it may be directly connected but unclear of procedure. ESD-E stated he would be sure to have a reduced pressure zone backflow preventer installed. On October 5, 2021, at 2:10 p.m., it was observed that the make-up water line to the boiler system in the fire sprinkler room was directly piped and was not protected by a backflow preventer. A reduced pressure zone backflow preventer is required. During the facility tour, ESD-E stated he did not know a backflow prevention device was required in this location. On October 5, 2021, ESD-E confirmed that the gutters and the above noted emergency lights required maintenance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar	0 810			

Minnesota Department of Health

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0 810	Continued From page 51 emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review and interview, facility failed to provide the required training and plans for fire safety and evacuation. This had the potential to affect all residents and staff. 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 the potential to affect a large portion or all of the residents).	0 810			

Minnesota Department of Health

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0 810	Continued From page 52 The findings include: On October 5, 2021, between 10:00 a.m. and 2:30 p.m., survey staff toured the facility with the environmental services director (ESD)-E. During the facility tour, surveyors observed no evacuation maps posted in main building 4195 and only two evacuation maps posted in secured dementia care building. These maps were located at the assisted living main entrance and in the hall by the entrance to the Adult Day Services area. The maps did not provide sufficient detail that would assist in determining your location and exit routes to take during evacuation. During the tour, ESD-E confirmed that the number of maps posted was insufficient for the facility and that the maps required more detail. On October 5, 2021, at approximately 2:45 p.m., ESD-E provided records for review. Records reviewed by survey staff on October 5, 2021, between 2:45 p.m. and 3:50 p.m. showed the following: 1. The fire safety and evacuation plans failed to include: a. the location and number of resident rooms b. fire protection procedures necessary for residents c. procedures for resident movement and identification of unique or unusual resident needs for movement or evacuation 2. Facility did not provide annual fire safety and evacuation training for residents. 3. Facility provided staff training for fire safety and evacuation in April and within 28 days of hire, but did not meet the twice per year training frequency requirement.	0 810			

Minnesota Department of Health

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0 810	Continued From page 53 On October 5, 2021, at approximately 4:00 p.m., the licensed assisted living director (LALD)-A and ESD-E confirmed that the facility did not provide the required content within the fire safety and evacuation plans. They also confirmed that the training frequency for staff and residents was not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 900 SS=E	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer	0 900			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD DULUTH, MN 55811			
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0 900	Continued From page 54 contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written Assisted Living Contract with the required content for three of six residents (R1, R9 and R10) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The facility converted to an Assisted Living with Dementia Care license on August 1, 2021. The resident records include a undated, unsigned Service Plan (Waiver)- Addendum Contract that indicated if signed by the resident, they received	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD DULUTH, MN 55811			
(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
0 900	Continued From page 55 an Assisted Living Contract. The licensee had multiple variations of Assisted Living Contracts which lacked the required content and signature. R1 R1's signed service plan dated April 8, 2021, indicated R1 received services which included medication administration, blood glucose monitoring, and shower assistance. On October 5, 2021, at approximately 6:30 a.m., unlicensed personnel (ULP)-I was observed administering medication to R1 and checking R1's blood glucose. R1's record included a Service Plan (Waiver)-Addendum Contract, unsigned and undated. R1's record did not include a written assisted living contract dated after August 1, 2021, to include the following required content: -a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. -the resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. During an interview on October 5, 2021, at approximately 2:05 p.m., licensed assisted living director (LALD)-A stated he made attempts to send R1's representative a new assisted living contract after converting to the Assisted Living/Dementia Care license on August 1, 2021.	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD DULUTH, MN 55811			
(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
0 900	Continued From page 56 He stated he had not received the signed contract back. Surveyor requested evidence of attempts made and what was sent to R1's representative. Surveyor did not receive requested evidence. R9 R9's record indicated he started services at the facility on December 27, 2019. R9's record included a Agreement to Services signed October 24, 2019. On October 5, 2021, at approximately 8:37 a.m., ULP-J was observed administering medication to R9. R9's record included a Service Plan (Waiver)-Addendum Contract, unsigned, and dated October 5, 2021. R9's record did not include a written assisted living contract dated after October 24, 2019, to include the following required content: -a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and -the resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. R10 R10's record included an Agreement to Services signed March 11, 2021. On October 5, 2021, at approximately 8:37 a.m., ULP-J was observed administering medication to R10.	0 900			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD DULUTH, MN 55811			
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0 900	Continued From page 57 R10's record included a Service Plan (Waiver)-Addendum Contract, unsigned, and dated October 7, 2021. R10's record did not include a written assisted living contract dated August 1, 2021, to include the following required content: -a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. -the resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. On October 6, 2021, at approximately 1:40 p.m., Registered Nurse (RN)-B stated R9 and R10 did not have signed Assisted Living Contracts with the required content. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900			
0 910 SS=D	144G.50 Subd. 2 Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address,	0 910			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD DULUTH, MN 55811		
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0 910	Continued From page 58 which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the Assisted Living Contract included the required content for one of six residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility converted to an Assisted Living with Dementia Care license on August 1, 2021. R1's record indicated R1 started services at the facility on October 30, 2015. R1's signed service plan dated April 8, 2021, indicated R1 received services which included medication administration, blood glucose monitoring, and shower assistance. On October 5, 2021, at approximately 6:30 a.m.,	0 910		

Minnesota Department of Health

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0 910	Continued From page 59 ULP-I was observed administering medication (oral, eye, injectable) to R1 and checking R1's blood glucose. R1's record included a written, unsigned assisted living contract dated on August 1, 2021, that did not include the name of the authorized agent for the facility. During an interview on October 5, 2021, at approximately 2:05 p.m., licensed assisted living director (LALD)-A stated he made attempts to send R1's representative a new assisted living contract after converting to the assisted living with dementia care license on August 1, 2021. He stated he had not received the signed contract back. The surveyor requested evidence of attempts made and what was sent to R1's representative. The surveyor did not receive requested evidence. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 920 SS=D	144G.50 Subd. 2 Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of	0 920			

Minnesota Department of Health

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0 920	Continued From page 60 the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and execute a written assisted living contract with the required content to two of six residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility converted to an Assisted Living with Dementia Care license on August 1, 2021.	0 920			

Minnesota Department of Health

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0 920	Continued From page 61 R1 R1's signed service plan dated April 8, 2021, indicated R1 received services which included medication administration, blood glucose monitoring, and shower assistance. On October 5, 2021, at approximately 6:30 a.m., unlicensed personnel (ULP)-I was observed administering medication to R1 and checking R1's blood glucose. R1's undated and unsigned Assisted Living Contract did not include a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license. R2 R2's signed service plan dated September 16, 2021, indicated services provided, which included medication administration, blood glucose monitoring, nebulizer treatments, dressing, grooming, toileting, and transfer assistance. On October 5, 2021, at approximately 6:55 a.m., ULP-I was observed administering oral medications and a nebulizer treatment to R2 and checking R2's blood glucose. R2's undated and unsigned Assisted Living Contract did not contain the following required content: -A disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license;	0 920			

Minnesota Department of Health

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0 920	Continued From page 62 and -a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated. On October 5, 2021, at approximately 2:05 p.m., licensed assisted living director (LALD)-A stated he made attempts to send R1 and R2's representatives a new assisted living contract after converting to the Assisted Living with Dementia Care license on August 1, 2021. He stated he had not received the signed contracts back. The surveyor requested evidence of attempts made and what was sent to R1 and R2's representatives. The surveyor did not recieve requested evidence. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 920			
0 930 SS=E	144G.50 Subd. 2 Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of	0 930			

Minnesota Department of Health

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0 930	Continued From page 63 residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and execute a written contract with the required content to provide assisted living services for four of six residents (R1, R2, R9 and R10) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The facility converted to an Assisted Living/Dementia Care license on August 1, 2021. R1 R1's signed service plan dated April 8, 2021, indicated R1 received services which included	0 930		

Minnesota Department of Health

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0 930	Continued From page 64 medication administration, blood glucose monitoring, and shower assistance. On October 5, 2021, at approximately 6:30 a.m., unlicensed personnel (ULP)-I was observed administering medication to R1 and to check R1's blood glucose. R2 R2's signed service plan dated September 16, 2021, indicated services provided, which included medication administration, blood glucose monitoring, nebulizer treatments, dressing, grooming, toileting, and transfer assist On October 5, 2021, at approximately 6:55 a.m., ULP-I was observed administering oral medications, nebulizer treatment, to R2 and to check R2's blood glucose. On October 5, 2021, at approximately 2:05 p.m., licensed assisted living director (LALD)-A stated he made attempts to send R1 and R2's representative a new assisted living contract after converting to the Assisted Living/Dementia Care license on August 1, 2021. He stated he had not received the signed contract back. Surveyor requested evidence of attempts made and what was sent to R1 and R2's representative. Surveyor did not receive requested evidence R9 R9's record indicated he started services at the facility on December 27, 2019. R9's record included a Agreement to Services signed October 24, 2019 which included medication administration. On October 5, 2021, at approximately 8:37 a.m., ULP-J was observed administering medication to R9.	0 930			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
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0 930	Continued From page 65 .R10 R10's record included a Agreement to Services signed March 11, 2021 which included medication administration. On October 5, 2021, at approximately 8:37 a.m., ULP-J was observed administering medication to R10. R1. R2, R9 and R10's record did not include a written assisted living contract to include the required content of the right under section 144G.54 to appeal the termination of an assisted living contract; and the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer. On October 6, 2021, at approximately 1:40 p.m., Registered Nurse (RN)-B stated R1, R2, R9 and R10 did not have signed Assisted Living Contracts with the required content. The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930			
0 940 SS=D	144G.50 Subd. 2 Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including:	0 940			

Minnesota Department of Health

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0 940	Continued From page 66 (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and execute a written Assisted Living Contract with the required content for two of six residents (R1, R2) with records reviewed.	0 940			

Minnesota Department of Health

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0 940	Continued From page 67 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility converted to an Assisted Living with Dementia Care license on August 1, 2021. R1 R1's signed service plan dated April 8, 2021, indicated R1 received services which included medication administration, blood glucose monitoring, and shower assistance. On October 5, 2021, at approximately 6:30 a.m., unlicensed personnel (ULP)-I was observed administering medication to R1 and checking R1's blood glucose. R2 R2's signed service plan dated September 16, 2021, indicated services provided which included medication administration, blood glucose monitoring, nebulizer treatments, dressing, grooming, toileting, and transfer assistance. On October 5, 2021, at approximately 6:55 a.m., ULP-I was observed administering oral medications and a nebulizer treatment to R2 and checking R2's blood glucose. R1's and R2's records included a unsigned and undated Assisted Living Contract the following required content:	0 940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD DULUTH, MN 55811			
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0 940	Continued From page 68 (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the Commissioner of Human Services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; On October 5, 2021, at approximately 2:05 p.m., licensed assisted living director (LALD)-A stated he made attempts to send R1 and R2's representatives a new Assisted Living Contract after converting to the Assisted Living with Dementia Care license on August 1, 2021. He stated he had not received the signed contracts back. The surveyor requested evidence of	0 940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
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0 940	Continued From page 69 attempts made and what was sent to R1 and R2's representatives. The surveyor did not receive requested evidence The licensee lacked policies to include the new Assisted Living Licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 940		
01170 SS=D	144G.56 Subd. 3 Notice required (a) A facility must provide at least 30 calendar days' advance written notice to the resident and the resident's legal and designated representative of a facility-initiated transfer. The notice must include: (1) the effective date of the proposed transfer; (2) the proposed transfer location; (3) a statement that the resident may refuse the proposed transfer, and may discuss any consequences of a refusal with staff of the facility; (4) the name and contact information of a person employed by the facility with whom the resident may discuss the notice of transfer; and (5) contact information for the Office of Ombudsman for Long-Term Care. (b) Notwithstanding paragraph (a), a facility may conduct a facility-initiated transfer of a resident with less than 30 days' written notice if the transfer is necessary due to: (1) conditions that render the resident's room or private living unit uninhabitable; (2) the resident's urgent medical needs; or (3) a risk to the health or safety of another resident of the facility.	01170		

Minnesota Department of Health

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01170	Continued From page 70 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, licensee failed to provide a 30-calendar day advance written notice to residents and/or the resident's legal/designated representative prior to initiating an in-facility move for one of one resident (R8) with a room location with records reviewed 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: R8 was admitted for services on August 1, 2021. R8's diagnoses included, but were not limited to, anxiety and asthma. R8's Notes dated August 10, 2021, indicated a 45 minute care conference was held with registered nurse (RN)-U and the resident's two daughters. They discussed the progression of dementia, poor safety awareness, behavior care plan, frequent falls, current medications, and the benefits of a memory care environment. The daughters are in need of more questions to be answered, such as size of the bedrooms in the memory care unit and the cost difference. The daughters were given a tour of the memory care unit. On August 27, 2021, R8 was transferred to	01170		

Minnesota Department of Health

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01170	Continued From page 71 the memory care unit. R8's Resident Agreement with a effective date of August 27, 2021, was signed by the resident's daughter on August 31, 2021. R8's record lacked evidence the licensee provided a 30-day written notification to R8 and the R8's legal and designated representative as required with the required content. On October 4, 2021, at approximately 10:30 a.m., licensed assisted living director (LALD)-A provided the Discharge Resident Roster for review. The Discharge Resident Roster indicated R8 was transferred from the assisted living building to the memory care building on August 27, 2021. On October 6, 2021, at approximately 7:34 a.m., RN-B stated the facility initiated the transfer to the memory care building because of the resident's increasing behaviors. RN-B stated a care conference was held with the family prior to transferring the resident to the memory care building. On October 6, 2021, at approximately 7:34 a.m., RN-B confirmed a 30 calendar day advanced written notice was not provided to R8 or R8's legal and designated representative. The licensee lacked policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021. Further information requested, but not provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01170			

Minnesota Department of Health

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01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	01470			

Minnesota Department of Health

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01470	Continued From page 73 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations for five of six unlicensed personnel ((ULP)-F, ULP-I, ULP-J, and ULP-K) with records reviewed. 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: ULP-F, ULP-I, ULP-J, and ULP-K's employee records lacked evidence they had received orientation to 144G licensing requirements in the	01470		

Minnesota Department of Health

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01470	Continued From page 74 following areas: - an overview of this chapter; - introduction and review of all the providers policies and procedures related to the provision of assisted living services under 144G statutes; and - principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-F began providing assisted living services for the licensee on August 1, 2021. On October 5, 2021, at approximately 7:00 a.m., ULP-F was observed administering R6's morning medications. ULP-I began providing assisted living services for the licensee on August 1, 2021. On October 5, 2021, at approximately 6:30 a.m., ULP-I was observed administering medication (oral, eye, injectable) to R1 and checking R1's blood glucose. ULP-J began providing assisted living services for the licensee on August 1, 2021. On October 5, 2021, at approximately 7:35 a.m., ULP-J was observed administering medications (oral, eyedrops, nasal spray) to R9. ULP-K began providing assisted living services for the licensee on August 1, 2021. On October 5, 2021, at approximately 6:40 a.m., ULP-K was observed assisting R11 with a two-person transfer, ambulation, grooming and toileting. On October 6, 2021, at approximately 2:00 p.m., registered nurse (RN)-B confirmed ULP-F, ULP-I,	01470			

Minnesota Department of Health

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01470	Continued From page 75 ULP-J , ULP-K and all employees who provided assisted living services for the licensee had not received the orientation training as indicated above. The licensee's policy titled, Staff Training, dated August 2020 did not include overview of 144G statutes, review of the provider's policies and procedures related to provision of assisted living services under 144G statutes and principles of person centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01620 SS=D	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for	01620			

Minnesota Department of Health

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01620	Continued From page 76 long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the Registered Nurse (RN) completed a comprehensive re-assessment following a change of condition for two of six residents (R3 and R4) with records reviewed. 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: R3 R3's record failed to include a reassessment by a RN following notification to the RN by Licensed Practical Nurses (LPN) that R3 had a change in condition associated with a indwelling catheter (catheter drains urine from the bladder into a bag outside of the body). R3's diagnoses included, but were not limited to, vascular dementia, (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), atrial fibrillation (an irregular often fast heart rate),	01620		

Minnesota Department of Health

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01620	Continued From page 77 and focal partial epilepsy (the seizure begins in one side of the brain and the person has no loss of awareness of their surroundings during it). R3's Assessment as of Date dated August 6, 2021, indicated R3 had a Foley catheter and required assistance from staff to maintain its use. Staff were directed to change the bag at morning and bedtime, assist with cleaning of the bags and assure the catheter was appropriately secured. Additionally, staff were directed to report observations of pain, changes to appearance of urine, sediment or blood appearing in tubing or bag, foul odors or changes in mentation or cognition of R3 to the LPN. R3's staff progress notes dated August 4, 2021, to September 30, 2021, included the following documentation in reference to the indwelling catheter: - August 11, 2021, unlicensed personnel documented in the resident record, "when changing to new leg bag we noticed his pee was a little darker than normal." - August 12, 2021, unlicensed personnel documented in the resident record, "slight blood show in urine." - August 18, 2021, unlicensed personnel documented in the resident record, "blood in urine, no blockage seen." - August 19, 2021, unlicensed personnel documented in the resident record, "night bag seems to be causing irritation/bleeding. Staff changed into day bag early due to small traces of blood in urine."	01620		

Minnesota Department of Health

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01620	Continued From page 78 - August 19, 2021, unlicensed personnel documented in the resident record, "bleeding from catheter from earlier shift seems to be under control since nurse from Caring Edge (out side agency) came and took care of him, no blood in urine, barely spotting in brief so far." - August 20, 2021, unlicensed personnel documented in the resident record, "resident had slight spotting but since nurse from Caring Edge came to care for resident bleeding issue seems to be under control, no blood in urine, tubing etc all intact." - August 26, 2021, unlicensed personnel documented in the resident record, "250, slight show of blood in urine but tubing looks to all be in place and running through properly at this point." - August 27, 2021, unlicensed personnel documented in the resident record, "resident had some blood show in brief from pulling readjusted so tubing had more slack when cleaning up had 400 ml output/urine clear." R3's nursing notes dated August 6, 2021, (last documented assessment) to September 23, 2021, indicate notification to the RN by LPN on the following dates: - August 16, 2021, a LPN documented in the resident record, "staff reported the resident had scant amount of blood in his leg bag early this morning. No complaints of pain when the LPN checked up on him. BP (blood pressure) 130/68, P (pulse) 61, T (temperature) 99.3, R (respirations) 20, O2 (oxygen saturation) 97%. CNP (certified nurse practitioner) and RN manager notified."	01620			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

EDGEWOOD HERMANTOWN I SR LVG

**4195 WESTBERG ROAD
DULUTH, MN 55811**

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01620	Continued From page 79 - August 19, 2021, a LPN documented into the resident record, "Caring Edge RN replaced resident catheter and brought new supplies. Resident had bright red blood on the tip of the penis and the urine is pinkish color due to trauma. Staff will monitor the resident. RN manager notified." R4 R4's record failed to include a reassessment by a RN following notification to the RN by an LPN of changes to the resident's skin condition. R4's diagnoses included, but were not limited to, vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), diabetes mellitus II (results from insufficient production of insulin, causing high blood sugar), and hypertension (high blood pressure). R4's Master Care Plan dated August 18, 2021, indicated R3 had active pressure ulcers in various stages of healing on left and right hip. The care plan directed staff to "keep watch, pink tissue." R4's nursing progress notes dated August 9, 2021, (last documented assessment) to September 23, 2021, included the following notifications to a RN: - August 15, 2021, LPN-M documented in the resident record that "staff had found a red spot measuring 0.3 x 0.3 cm on the right hip" and two RNs had been notified. - August 19, 2021, LPN-M documented in the resident record that "staff found a pressure sore on the residents left hip measuring 0.5 x 0.5 cm" and the RN manager was notified.	01620		

Minnesota Department of Health

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01620	Continued From page 80 - August 24, 2021, a LPN documented "resident has had an increase of shortness of breath this shift." - September 16, 2021, LPN-V documented "resident is lethargic and has a low grade temp, no intake this shift." R3 and R4's record lacked evidence the RN reassessed the resident's change of condition after being notified of the resident's change in condition. On October 6, 2021, at approximately 1:26 p.m., RN-B confirmed R3 and R4's records lacked a reassessment by a RN following a change in condition. Licensee's Assessments policy, dated August 2020, indicated an RN is responsible for evaluating a significant change in resident condition. Furthermore, indicating that a change in condition is defined as - any deviation from the residents typical clinical baseline. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=E	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must	01640		

Minnesota Department of Health

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01640	Continued From page 81 include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure service plans were developed for two of eight residents (R9 and R10) and failed to ensure service plans were revised for two of six residents (R3 and R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R9 and R10 records lacked evidence the licensee developed a service plan.	01640			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD DULUTH, MN 55811		
(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
01640	Continued From page 82 R9 R9's record indicated he started services at the facility on December 27, 2019. R9's diagnoses included, but were not limited to, dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), depression (negatively affects how you feel, the way you think and how you act), and anxiety (intense, excessive and persistent worry and fear about everyday situations). On October 5, 2021, at approximately 8:37 a.m., unlicensed personnel (ULP)-J was observed to administering R9's morning medications. R10 R10's record indicated she started services at the facility on March 9, 2021. R10's diagnoses included, but were not limited to, mixed Alzheimer's and vascular dementia (brain changes of more than one cause of dementia occur simultaneously), urinary incontinence (involuntary urination), Impingement syndrome (can occur together with rotator cuff tendonitis or shoulder bursitis), and recurrent major depressive disorder (mental health disorder having episodes of psychological depression). On October 5, 2021, at approximately 8:45 a.m., ULP-J was observed administering R10's scheduled morning medications. R3 and R4's records lacked documentation the licensee revised the service plan to include provided services. R3	01640		

Minnesota Department of Health

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01640	Continued From page 83 R3's diagnoses included, but were not limited to, vascular dementia, (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), atrial fibrillation (an irregular often fast heart rate), and focal partial epilepsy (the seizure begins in one side of the brain and the person has no loss of awareness of their surroundings during it). On October 5, 2021, at approximately 8:27 a.m., ULP-K was observed documenting a 30-minute safety check into a binder book for R3. R3's service plan dated November 22, 2020, did not identify R3 received 30-minute safety check services. R4 R4's diagnoses included, but were not limited to, vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), diabetes mellitus II (results from insufficient production of insulin, causing high blood sugar), and hypertension (high blood pressure). On October 5, 2021, at approximately 8:30 a.m., R4's name was located on the roster and documentation by staff that 30-minute safety checks were completed for R4. R4's service plan dated July 1, 2021, did not identify R4 received 30-minute safety checks. On October 5, 2021, at approximately 7:10 a.m., R4 was observed being assisted by two staff with a brief change and peri-care.	01640			

Minnesota Department of Health

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01640	Continued From page 84 On October 5, 2021, at approximately 2:30 p.m., registered nurse (RN)-B confirmed licensee failed to develop a service plan for R9 and R10. RN-B confirmed service plans had not been revised as required for R3 and R4. The licensee's Service Planning/Care Planning and Coordination of Care policy dated August 2020 indicated service plans would be completed within 14 days of initiation of services and service plans would be revised, as needed, based on resident review or assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications;	01730		

Minnesota Department of Health

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01730	Continued From page 85 (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure individual medication management plans contain all the required content for two of eight residents (R3 and R4) with records reviewed. 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	01730			

Minnesota Department of Health

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01730	Continued From page 86 situation has occurred only occasionally). The findings include: During the entrance conference on October 4, 2021, at approximately 10:30 a.m., the licensed assisted living director (LALD)-A and Registered Nurse (RN)-B confirmed the licensee provided medication management services to the majority of residents at the facility. R3's diagnoses included, but were not limited to, vascular dementia, (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), atrial fibrillation (an irregular often fast heart rate), and focal partial epilepsy (the seizure begins in one side of the brain and the person has no loss of awareness of their surroundings during it). R3's service plan dated November 22, 2020, indicated R3 received medication management services. R3's prescriber orders dated July 3, 2021, included but was not limited to, two mild pain relievers, one anti-hypertensive, one blood thinner, one anti-depressant, one anti-seizure, one medication to treat heartburn, one cholesterol reducer, two anti-acids, one nutritional supplement and two sleep aides. R4's diagnoses included, but were not limited to, vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), diabetes mellitus II (results from insufficient production of insulin, causing high blood sugar), and hypertension (high blood pressure).	01730			

Minnesota Department of Health

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01730	Continued From page 87 R4's service plan dated July 1, 2021, indicated R4 received medication management services. R4's prescriber orders Current As of Date October 5, 2021, included, but was not limited to, one mood stabilizer, one stool softener, two pain reducers, one non-opioid replacement, two sleep aides, one anti-anxiety, and one as needed inhaler. On October 5, 2021, at approximately 8:05 a.m., Licensed Practical Nurse (LPN)-V was observed administering scheduled morning medications to R4. R3 ND R4's medication management record failed to include the following: - a description of storage of medications based on the resident's needs and preferences, and consistent with manufacturer's directions, - documentation of specific resident instructions relating to the administration of medications, - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis, - identification of medication management tasks that may be delegated to ULP, - procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services, - any resident-specific requirements relating to documenting medication administration,	01730			

Minnesota Department of Health

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01730	Continued From page 88 verification that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions, and, -completion of medication reconciliation. On October 7, 2021, at approximately 9:45 a.m., RN-B confirmed licensee failed to develop an individualized medication management plan to include the above noted content as required for R3 and R4. The licensee's Medication Management Services Policy dated February 2016 indicated each resident that requests medication management services would be assessed by a licensed professional, RN or authorized provider prior to providing medication management services. The assessment would be conducted face to face identifying and reviewing all medications resident is known to be taking and identify interventions to prevent diversion. The policy did not address any other items required within an individualized medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
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	01760			

Minnesota Department of Health

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01760	Continued From page 89 must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were documented after administration for one of six residents (R2), failed to ensure medications were administered as ordered for three of six (R4, R9 and R10), and failed to ensure the effectiveness of as needed (PRN) medications were documented for one of six residents (R10) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Documentation of Medications Prior to Administration R2 R2's diagnoses included, but were not limited to, lung cancer.	01760			

Minnesota Department of Health

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01760	Continued From page 90 R2's service plan dated September 16, 2021, indicated R2 received services which included medication administration, blood glucose monitoring, nebulizer treatments, dressing, grooming, toileting, and transfer assistance. R2's Individualized Medication Management Plan, undated, indicated R2 received medication management services, including assistance with oral medications and nebulizer treatment. R2's prescriber orders dated September 15, 2021, included, but was not limited to, orders for ipratropium albuterol 0.5- 2.5 milligrams (mg) nebulize 3 milliliters (ml) into the lungs every six hours. On October 5, 2021, at approximately 6:45 a.m., unlicensed personnel (ULP)-I was observed preparing medications for R2, which included oral medications and nebulizer medication. ULP-I removed oral medications for R2 and put them into a medication cup. ULP-I removed one ipratropium albuterol 0.5-2.5 mg 3 ml dose vial from the medication cart. ULP-I brought R1's medication cup of oral medications and one ipratropium albuterol 0.5-2.5 mg dose vial into R2's apartment. ULP-I handed the medication cup of oral medications to R2. R2 swallowed pills followed by a drink of water. ULP-I added the ipratropium albuterol 0.5-2.5 mg dose vial into the nebulizer mouthpiece treatment reservoir. ULP-I told R2 the nebulizer treatment was all set for her to self-administer and told R2 she would be back in 20 minutes to check in. ULP-I removed gloves, returned to the medication cart and documented administration of R2's ipratropium albuterol 0.5-2.5 mg 3 ml dose. On October 5, 2021, at approximately 7:05 a.m.,	01760			

Minnesota Department of Health

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01760	Continued From page 91 ULP-I verified she documented administration of R2's ipratropium albuterol 0.5-2.5 mg dose vial prior to administering the medication to the residents. On October 6, 2021, at approximately 2:30 p.m., Registered Nurse (RN)-B, stated staff should not have documented R2's nebulizer treatment as administered without witness of administration. The licensee's policy titled, Medication Administration, dated August 2020 indicated staff would document the administration of medication on the medication record after the medication had been administered. Medication Not Administered as Ordered/Medication Errors R4 R4's diagnoses included, but were not limited to, vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), diabetes mellitus II (results from insufficient production of insulin, causing high blood sugar), and hypertension (high blood pressure). R4's service plan dated July 1, 2021, indicated R4 received services, which included medication administration seven times a day and as needed (PRN). R4's Individualized Medication Management Plan dated September 17, 2021, indicated R4 received medication administration services, and R4's medications would be securely stored by the provider in the locked medication cart which could only be accessed by staff.	01760			

Minnesota Department of Health

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01760	Continued From page 92 R4's Medications Current as of dated October 5, 2021, included, but were not limited to, the following: - ducosate 50/8.6 milligram (mg) to be administered by mouth once daily for constipation, - divalproex 125 mg take two caps (250) mg by mouth three times daily for mood; and, - gabapentin 300 mg one tablet three times daily by mouth for pain; and, - methadone 5 mg three times daily by mouth for pain; and, - pain reliever 500 mg take two tabs (1000) mg by mouth three times daily for pain. R4's medication administration records (MAR) from September 1, 2021, to September 30, 2021, indicated the following: - ducosate 50/8.6 mg was not administered twenty out of thirty days; - divalproex 125 mg was not administered one out of thirty days; - gabapentin 300 mg was not administered one out of thirty days; - methadone 5 mg was not administered one out of thirty days; - pain reliever 500 mg was not administered one out of thirty days.	01760			

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01760	Continued From page 93 On October 6, 2021, at approximately 2:37 p.m., RN-B confirmed staff had failed to administer physician ordered medications to R4. R9 R9's diagnoses included, but were not limited to, dementia (loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), depression (negatively affects how you feel, the way you think and how you act), and anxiety (intense, excessive and persistent worry and fear about everyday situations). R9's Edgewood Leveling Tool - MC dated December 10, 2020, indicated R9 received services, which included medication administration up to three times a day and PRN. R9's Individualized Medication Management Plan dated August 18, 2021, indicated R9 received medication administration services, and R9's medications would be securely stored by the provider in the locked medication cart which could only be accessed by staff. R9's Medications Current as of dated October 7, 2021, included, but was not limited to, the following: - quetiapine 25 mg take half-tab (12.5) mg by mouth to be administered once daily for sleep; - atorvastatin 40 mg by mouth one time daily for cholesterol; - duloxetine 60 mg by mouth one time daily for depression; - gabapentin 300 mg by mouth one time daily for	01760			

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01760	Continued From page 94 neuropathy pain; - melatonin 3 mg take three tabs (9) mg by mouth one time daily for sleep; - memantine 10 mg one tab twice daily by mouth for dementia; and - tamsulosin 0.4 mg by mouth one tab daily for enlarged prostate. R9's medication administration records (MAR) from September 1, 2021, to September 30, 2021, indicated the following: - quetiapine 25 mg was not administered twenty out of thirty days; - atorvastatin 40 mg was not administered one out of thirty days; - gabapentin 300 mg was not administered one out of thirty days; - melatonin 3 mg was not administered one out of thirty days; - duloxetine 60 mg was not administered one out of thirty days; - memantine 10 mg was not administered one out of thirty days; - tamsulosin 0.4 mg was not administered one out of thirty days. On October 6, 2021, at approximately 2:37 p.m., RN-B confirmed staff had failed to administer physician ordered medications to R9.	01760		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

EDGEWOOD HERMANTOWN I SR LVG

**4195 WESTBERG ROAD
DULUTH, MN 55811**

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01760	Continued From page 95 R10 R10's diagnoses included, but were not limited to, mixed Alzheimer and vascular dementia (brain changes of more than one cause of dementia occur simultaneously), urinary incontinence (involuntary urination), Impingement syndrome (can occur together with rotator cuff endpoints or shoulder bursitis), recurrent major depressive disorder (mental health disorder having episodes of psychological depression). R10's Medications - Current as of dated October 5, 2021, indicated the resident received medication administration five times a day and PRN. R10's physician orders dated March 13, 2021, included, but was not limited to; - lorazepam 0.25 mg to be administered daily by mouth PRN. R10's MAR from September 1, 2021, to September 30, 2021, indicated the following: - lorazepam 0.25 mg PRN had been administered twice daily on two out of thirty days. On October 6, 2021, at approximately 2:40 p.m., RN-B confirmed staff had failed to administer the PRN medication as ordered by the physician for R10. R10's Individualized Medication Management Plan dated October 7, 2021, indicated R10 received medication administration services, and R10's medications would be securely stored by the provider in the locked medication cart which could only be accessed by staff.	01760		

Minnesota Department of Health

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01760	Continued From page 96 PRN Effectiveness R10 R10's diagnoses included, but were not limited to, mixed Alzheimer's and vascular dementia (brain changes of more than one cause of dementia occur simultaneously), urinary incontinence (involuntary urination), Impingement syndrome (can occur together with rotator cuff endpoints or shoulder bursitis), and recurrent major depressive disorder (mental health disorder having episodes of psychological depression). R10's physician orders dated March 13, 2021, included, but were not limited to: - lorazepam 0.25 mg by mouth daily PRN; and - oxycodone immediate release 5 mg one tab every hour PRN for moderate to severe pain 4 to 10 on the pain scale. R10's MAR from September 1, 2021, to September 30, 2021, indicated the following: - lorazepam 0.25 mg by mouth daily PRN; two out of eleven administrations no effectiveness documented, five out of eleven administrations documentation of effectiveness was completed beyond sixty minutes; - oxycodone immediate release 5 mg by mouth every hour PRN for moderate to severe pain 4 to 10 on a pain scale; documentation of effectiveness was completed beyond sixty minutes for 40 out of 63 administrations. R10's Medications - Current as of dated October	01760		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD DULUTH, MN 55811			
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01760	Continued From page 97 5, 2021, indicated R10 received medication administration five times a day and PRN. R10's Individualized Medication Management Plan dated October 7, 2021, indicated R10 received medication administration services, and R10's medications would be securely stored by the provider in the locked medication cart which could only be accessed by staff. On October 6, 2021, at approximately 2:40 p.m., RN-B confirmed staff did not document the effectiveness following administration of the PRN medications as ordered by the physician for R10. The licensee's Medication Administration Policy dated August 2020 indicated staff must document a follow-up for PRN medication administration within sixty minutes from the time of administration. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and	01790			

Minnesota Department of Health

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01790	Continued From page 98 (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the	01790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

EDGEWOOD HERMANTOWN I SR LVG

**4195 WESTBERG ROAD
DULUTH, MN 55811**

(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
01790	Continued From page 99 completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure three of three unlicensed personnel ((ULP)-F, ULP-H, and ULP-J) were trained and had demonstrated competency to prepare and give medications for clients having unplanned time away. In addition, the licensee failed to ensure the Registered Nurse (RN) developed written procedures for unplanned time away from home. This had the potential to affect all the 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), 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: During the entrance conference on October 4, 2021, at approximately 10:30 a.m., the licensed assisted living director (LALD)-A and RN-B confirmed the licensee provided medication management services to the majority of residents at the facility. On October 4, 2021, at approximately 10:50 a.m., RN-B confirmed the ULP would prepare and send medications with the residents for unplanned times away.	01790		

Minnesota Department of Health

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01790	Continued From page 100 UNPLANNED TIMES AWAY POLICY AND PROCEDURE FOR ULP Licensee failed to develop and implement a written procedure for the ULP providing medications for clients having unplanned times away. The licensee's Resident Leave Medication policy dated August 2020, indicated for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall give the resident resident's representatives medications in amounts and dosages needed for the length of the anticipated absence, not to exceed 120 hours. The licensee's policy lacked a written procedure to include: -proving the resident with written information on medications, including any specific instructions for administering or handling the medications, including controlled substances; - the type of container or containers to be used for the medications appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; and - how the RN would be notified that medications have been provided and whether the RN needed to be contacted before the medications are given to the resident or the designated representative.	01790			

Minnesota Department of Health

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01790	Continued From page 101 On October 6, 2021, at approximately 2:00 p.m., RN-B confirmed the licensee's Resident Leave Medication policy did not include the above noted written procedure as required. TRAINING AND COMPETENCY EVALUATIONS ULP F ULP-F was hired on August 1, 2021, to provide direct care services for the licensee's residents which included medication administration. On October 5, 2021, at approximately 7:00 a.m., ULP-F was observed administering R6's scheduled morning medications. ULP-I ULP-I was hired on August 1, 2021, to provide direct care services for the licensee's residents which included medication administration. On October 5, 2021, at approximately 6:55 a.m., ULP-I was observed administering oral medications and treatments to R2 to include a nebulizer treatment and blood glucose (sugar) monitoring. ULP-J ULP-J was hired on August 1, 2021, to provide direct care for the licensee's residents which included medication administration. On October 5, 2021, at approximately 7:35 a.m., ULP-J was observed administering medications (oral, eyedrops, nasal spray) to R9. ULP-F, ULP-I and ULP-J's record lacked evidence to indicate ULP-F, ULP-I and ULP-J had	01790			

Minnesota Department of Health

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01790	Continued From page 102 been trained and had demonstrated competency to prepare and provide medications to residents for unplanned times away from home. On October 6, 2021, at approximately 2:00 p.m., RN-B confirmed ULP-F, ULP-I and ULP-J had not been trained and had not demonstrated competency to prepare and provide medications to residents for unplanned times away from home. The licensee's Resident Leave Medication policy dated August 2020, noted for unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel as long as the registered nurse had trained and determined the unlicensed staff was competent to give medications to clients and there were written procedures for unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=E	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 medications were stored according to manufactures	01880		

Minnesota Department of Health

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01880	Continued From page 103 recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). On October 6, 2021, at approximately 7:45 a.m., Registered Nurse (RN)-B provided the surveyor temperature monitoring documentation for the facility's medication refrigerators. RN-B stated facility staff were assigned a daily task called a "chore" for temperature monitoring and checked temperatures daily. RN-B provided a facility document titled, Chore Recap by Chore Type. RN-B verified she knew there were issues with temperatures not taken daily. When asked if she knew what temperature range the medication refrigerator needed to be maintained at for medication storage, she said she would need to look at the facility's policy. Main Building-Front Area A review of the Chore Recap by Chore Type dated August 1, 2021, to October 6, 2021, included a chore indicating "Medication Refrigerator Temperature Log: Record daily temperature for the medication refrigerator." The same document did not include identification of refrigerator temperature ranges for the medication refrigerator and instructions of what to do if temperature was outside of range. A review of the Chore Recap by Chore Type for	01880			

Minnesota Department of Health

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01880	Continued From page 104 the medication refrigerator located in the front nurses area of the assisted living indicated the following: Record lacked temperature checks: - September 2, 3, 6, 11, 14, 16, 20, 21, 22, 23, 24, 25, 28, 29, 20, 21, 22, 23, 24, 25, 28, 29, and 30, 2021; and - October 1, 2, and 4, 2021. Refrigerator logs indicated temperatures were out of the manufacturer recommended range of 36 to 46 degrees on - September 4, 5, 12, 13, 15, 17, 18, 19, 26, and 27, 2021; and - October 3 and 5, 2021. On October 6, 2021, at approximately 8:08 a.m., RN-R verified the refrigerator temperature located in the front assisted living measured 41 degrees Fahrenheit (F). The medication refrigerator included the following medications: -three boxes of Basaglar Kwikpen U-100 insulin pens (multiple dose pen shaped injector device used for insulin administration); -one box of Forteo (teriparatide injection) (multiple dose pen shaped injector device to treat bone loss); -two boxes of Tresiba FlexTouch insulin pens; -one box of Novolin 70/30 insulin pens;	01880		

Minnesota Department of Health

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01880	Continued From page 105 -one box of Lantus Solostar insulin pens; and -three bottles of Lantropost ophthalmic solution (eye drops used to treat high pressure inside the eye). The manufacturer's instructions for Basaglar Kwikpen U-100 Insulin pens indicated store the insulin pens in the refrigerator between 36 to 46 degrees F. The manufacturer's instructions for Forteo injection pen indicated to store the Forteo pen in the refrigerator between 36 to 46 degrees F. The manufacturer's instructions for Tresiba FlexTouch insulin pens indicated store the insulin pens in the refrigerator between 36 to 46 degrees F. The manufacturer's instructions for Novolin 70/30 insulin pens indicated store the insulin pens in the refrigerator between 36 to 46 degrees F. The manufacturer's instructions for Lantus Solostar insulin pens indicated store the insulin pens in the refrigerator between 36 to 46 degrees F. The manufacturer's instructions for Lantropost ophthalmic solution indicated store the ophthalmic solution in the refrigerator between 36 to 46 degrees F. Main Building-Back Area A review of the Chore Recap by Chore Type for the medication refrigerator located in the back assisted living indicated the following	01880		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
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01880	Continued From page 106 measurements: Record lacked temperature checks: - September 4 and 26, 2021 Refrigerator logs indicated temperatures were out of the manufacture recommended range: - September 2, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 27, 28, 29, and 30, 2021; and - October 1, 2, 3, and 4, 2021. A review of the Chore Recap by Chore Type for the medication refrigerator located in the middle assisted living indicated the following measurements: Record lacked temperature checks: - September 3, 4, 5, 7, 8, 12, 15, 17, 18, 19, 22, 23, 26, 28, and 29, 2021; and - October 1, 2, 3, and 5, 2021. Refrigerator logs indicated temperatures were out of the manufacturer recommended range: - September 2, 6, 10, 16, 21, and 30, 2021 On October 6, 2021, at approximately 2:30 p.m., RN-B stated it was an expectation staff check all medication refrigerator temperatures daily. Memory Care Unit On October 5, 2021, at approximately 8:20 a.m., RN-T provided access to a locked medication refrigerator located in Pod-B of the detached	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
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01880	Continued From page 107 memory care. RN-T stated staff check the temps and document the temps into RTasks everyday, "usually on nights". RN-T confirmed one full box of Lantus insulin pens were stored in the refrigerator at the time of observation. Current temp noted on thermometer at time of observation, 34 degrees Fahrenheit (F). On October 6, 2021, at approximately 7:43 a.m., RN-T provided a report, Chore Recap by Specific Chore, dated September 1, 2021 to October 5, 2021. RN-T confirmed the refrigerator temperature report indicated refrigerator temperatures were out of manufacturer recommended parameters for storage of insulin and were missing numerous days of documentation. RN-T was asked if the ranges of proper temperature was known, RN-T stated, "I don't know, 34 to 40?" A review on October 6, 2021, at approximately 8:00 a.m., of the Chore Recap by Specific Chore report for the medication refrigerator located in Pod-B of the memory care unit indicated the following: Record lacked temperature checks: - September 4, 11, 18, 25, 26, 2021; and - October 1, 2, 2021. Refrigerator logs indicated temperatures were out of the manufacture recommended range: - September 1, 2, 3, 5, 6, 7, 8, 9, 12, 13, 14, 15, 16, 17, 19, 20, 21, 22, 23, 29, 30, 2021; and - October 4, 5, 2021.	01880			

Minnesota Department of Health

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01880	Continued From page 108 On October 5, 2021, at approximately 8:20 a.m., RN-T confirmed the medication refrigerator contained the following medication for storage: -one full box of Lantus insulin pens, ten (10) count. The manufacturer's instructions for Lantus Solostar insulin pens indicated store the insulin pens in the refrigerator between 36 to 46 degrees F. On October 6, 2021, at approximately 8:00 a.m., RN-T confirmed the refrigerator temperature report showed refrigerator temperatures were outside of manufacture recommended parameters for the storage of insulin and were missing numerous days of documentation. The licensee's policy titled Refrigerator/Freezer Monitoring, dated August 2020, indicated staff must check weekly, or more often as state regulation requires, confirming that the refrigerator used to store medications maintains a temperature between 36 and 46 degrees. The same policy indicated staff should be instructed that temperatures outside of this range must be reported to the supervisor immediately. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed	01890			

Minnesota Department of Health

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01890	Continued From page 109 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 time sensitive medications were labeled with the open date for one of two residents (R1) with records reviewed. In addition, the licensee administered an expired medication to one of six residents (R2) reviewed. 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). R1 R1's diagnoses included, but were not limited to, type II diabetes, obesity, and hypertension. R1's prescriber orders dated January 21, 2021, included the following injectable medication: - Tresiba 200, 200 unit/milliliters (ml) suspension; inject 50 units under the skin daily in the AM. R1's Individualized Medication Management Plan dated September 19, 2021, indicated R1 received medication management services, including assistance with injectable medications. On October 5, 2021, at approximately 6:20 a.m.,	01890		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD DULUTH, MN 55811			
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01890	Continued From page 110 unlicensed personnel (ULP)-I was observed to prepare medications for R1, which included oral medications, eye drops, and use of an insulin pen. ULP-I placed R1's oral medications into a medication cup. ULP-I removed R1's eyedrops and Tresiba insulin pen from the medication cart. R1's Tresiba insulin pen lacked a label indicating the date opened and expiration date. On October 5, 2021, at approximately 6:20 a.m., ULP-I verified R1's Tresiba insulin pen lacked a date opened label and said the insulin pen should have been labeled with a date opened and the expiration date. The manufacturer's instructions for Tresiba insulin pen indicated the pen should be discarded after 56 days. R2 R2's diagnoses included, but were not limited to, lung cancer. R2's Individualized Medication Management Plan, undated, indicated R2 received medication management services. R2's prescriber orders dated September 15, 2021, included orders for Pumpkin Seed-Soy Gem (AZO bladder control) take one capsule by mouth twice daily. During an observation on October 5, 2021, at approximately 6:45 a.m., ULP-I prepared medications for R2, which included oral medications. During oral medication preparation, ULP-I removed R2's bottle of Pumpkin Seed-Soy Gem (AZO bladder control) capsules from the medication cart. ULP-I opened the bottle and was about to add the capsule to the medication cup	01890			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
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01890	Continued From page 111 containing R2's other oral medications when surveyor stopped her. Surveyor asked ULP-I to look at R2's AZO bladder control medication bottle expiration date. The AZO bladder control medication expired July 2021. On October 5, 2021, at approximately 6:45 a.m., ULP-I verified R2's AZO bladder control medication expired and verified she would have administered expired medication to R2 without surveyor intervention. On October 6, 2021, at approximately 2:30 p.m., Registered Nurse (RN)-B stated it was an expectation time sensitive medication, such as insulin pens, would be labeled with a date opened and the expiration date. RN-B stated it was an expectation staff checked for expiration dates during medication administration and checked for expired medications in the medication cart. The licensee's policy titled, Medication Storage, dated August 2020 indicated all medications must be dated when opened and discarded on or prior to expiration date. The same policy indicated expiration dates would be monitored to prevent outdated medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy management For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare	01940			

Minnesota Department of Health

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01940	Continued From page 112 and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop a treatment management plan to include all required content for one of six residents (R4) receiving treatment management services with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
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01940	Continued From page 113 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's record lacked evidence a treatment management plan had been developed. R4's diagnoses included, but were not limited to, vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), diabetes mellitus II (results from insufficient production of insulin, causing high blood sugar), and hypertension (high blood pressure). R4's service plan dated July 1, 2021, indicated R4 received oxygen management services one day a week and three times daily. On October 6, 2021, at approximately 7:50 a.m., Licensed Practical Nurse (LPN)-V was observed assisting R4 with transportation of an oxygen concentrator to the dining room and placement of a nasal cannula. LPN-V verified the oxygen setting to be at 2 liters per minute (LPM). LPN-V verified the unlicensed personnel assisted R4 with the oxygen, R4 lacked an Individualized Treatment Therapy Management Plan that contained the following: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatment or therapy	01940		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
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01940	Continued From page 114 administration; -identification of the treatment or therapy that will be delegated to unlicensed personnel; -procedures for notifying a nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and -any resident-specific requirements relating to documenting of treatment and therapy received' verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On October 6, 2021, at approximately 2:40 p.m., Registered Nurse (RN)-B confirmed that an Individualized Treatment and Therapy Plan had not been developed or implemented for R4 as required. The licensee's Treatment and Therapy Management Services Policy, undated, did not address the development of an individualized therapy management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
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01950	Continued From page 115 perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the Registered Nurse (RN) specified, in writing, specific instructions for one of six residents (R4) receiving treatment management services with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
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01950	Continued From page 116 R4's diagnoses included, but were not limited to, vascular dementia (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), diabetes mellitus II (results from insufficient production of insulin, causing high blood sugar), and hypertension (high blood pressure). R4's service plan dated July 1, 2021, indicated R4 received oxygen management services one day a week and three times daily, assistance with dressing, grooming, bathing, hygiene, medication administration, housekeeping and laundry. R4's physician orders dated August 11, 2021, indicated oxygen be provided at 2 LPM (liters per minute) to keep oxygen saturation levels above 88%, (oxygen saturation is the fraction of oxygen-saturated hemoglobin relative to total hemoglobin in the blood. Normal arterial blood oxygen saturation levels in humans are 95-100 percent). On October 6, 2021, at approximately 7:50 a.m., Licensed Practical Nurse (LPN)-V was observed assist R4 with transportation of an oxygen concentrator to the dining room and placement of a nasal cannula. LPN-V verified the oxygen setting was physician ordered to be set at 2 LPM. LPN-V indicated the unlicensed personnel assist R4 with oxygen. R4's record lacked an individualized treatment or therapy plan that would have instructed staff how often to check oxygen saturation levels and when a nurse should have been notified of the results. R4's Service Recap summary dated October 2021 indicated oxygen management, no other instructions noted, had been conducted daily.	01950			

Minnesota Department of Health

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01950	Continued From page 117 On October 7, 2021, at approximately 9:50 a.m., Registered Nurse (RN)-B confirmed R4's record lacked written oxygen instructions. The licensee's Treatment & Therapy Management Plan policy, undated, did not address specific instructions for each resident or the documentation of those instructions into the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatments for one of six residents (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or	01960			

Minnesota Department of Health

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01960	Continued From page 118 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: R3's record lacked documentation of treatments provided. R3's diagnoses included, but were not limited to, vascular dementia, (condition caused by the lack of blood that carries oxygen and nutrient to a part of the brain), chronic obstructive pulmonary diseases (COPD-chronic obstruction of lung airflow that interferes with normal breathing), atrial fibrillation (an irregular often fast heart rate), and focal partial epilepsy (the seizure begins in one side of the brain and the person has no loss of awareness of their surroundings during it). R3's service plan dated November 22, 2020, indicated R3 received medication management, dressing, hygiene, catheter care, anticoagulation, housekeeping and laundry. On October 6, 2021, at approximately 7:23 a.m., Licensed Practical Nurse (LPN)-V was observed assisting R3 with ambulation, insertioun of hearing aides, cleaned and apply eye glasses and verifing the catheter leg bag was intact. On October 6, 2021, at approximately 2:30 p.m., a record review of R3's Service Recap Summary-September 2021 through October 2021, indicated staff failed to document catheter cares as follows: - September 11, 2021; and	01960		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
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01960	Continued From page 119 - October 2 (3:00 p.m. and 7:00 p.m.) and 3 (2:00 a.m. and 4:00 a.m.), 2021. On October 7, 2021, at approximately 10:00 a.m., Registered Nurse (RN)-B confirmed R3's record lacked the documentation of completed services as required. The licensee's Resident Records/Documentation policy dated August 2020 indicated the resident record would include documentation that services had been provided as identified in the Care Plan/Service Plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02040 SS=E	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 observation, record review and	02040		

Minnesota Department of Health

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02040	Continued From page 120 interview, the licensee failed to provide a hazard vulnerability or safety risk assessment that included hazards identified on and around the property. Mitigation of hazards to protect residents from harm was not included in the plan. This had the potential to affect all dementia care 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly but is not found to be pervasive). The findings include: On October 5, 2021, between 10:00 a.m. and 2:30 p.m., during a tour of the facility with environmental services director (ESD)-E, the following hazards and safety risks were observed: Memory Care - the fence in the resident outdoor recreation area had gaps at the bottom that were large enough to allow a person to crawl out of the secured area. The recreation area was accessible to residents exiting from A and B Pods. On October 5, 2021, ESD-E stated there were ongoing problems with the ground heaving in this area. He explained that wire had been installed along the bottom edge of this fence in some areas to seal gaps, but it was observed that not all gaps were sealed;	02040			

Minnesota Department of Health

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02040	Continued From page 121 - the kitchen service counter had not had a rolling door or other form of closure mechanism installed to secure the space. On October 5, 2021, ESD-E stated kitchen doors were locked, but equipment is not disconnected or securely stored when the kitchen was not staffed. Main Building 4195 - the gas fireplace did not have prevention measures in place to protect residents from contacting hot surfaces when the fireplace was used and the switch to turn on and off the gas fireplace was the same style as a single pole light switch. On October 5, 2021, ESD-E stated that the gas fireplace was used under staff supervision and was turned on and off with the use of the switch located on the wall. - one electrical panel in the Adult Day Services area was not locked. On October 5, 2021, ESD-E confirmed that the electrical panel should have been locked. - dementia care residents must walk through the main assisted living building to access the enclosed courtyards. On October 5, 2021, ESD-E stated that the courtyards were designated as recreational outdoor space for dementia care residents. On October 5, 2021, at approximately 2:45 p.m., the ESD-E provided records for review, which	02040			

Minnesota Department of Health

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02040	Continued From page 122 included a Hazard Vulnerability Assessment. On October 5, 2021, between 2:45 p.m. and 3:50 p.m., the Hazard Vulnerability Assessment identified hazards within the community and the distance of these hazards from the facility but did not include, hazards on and around the property. Mitigation of hazards was not included in the plan. On October 5, 2021, at approximately 4:00 p.m., the licensed assisted living director (LALD)-A and ESD-E confirmed that the facility failed to include hazards or safety risks specific to the property on the hazard vulnerability assessment and mitigation of hazards or safety risks to protect residents from harm was not included in the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed;	02110		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
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02110	Continued From page 123 (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, licensee failed to ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed and failed to provided the policies and procedures to residents and the residents' legal and designated representatives at the time of move-in. This had the potential to affect all the clients in the memory care units. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	02110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 10/07/2021
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02110	Continued From page 124 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee failed to develop and implement policies and procedures that addressed: - philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; - wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; - medication management, including an assessment of residents for the use and effects of medication, including psychotropic medications; - staff training specific to dementia care; - description of life enrichment programs and how activities are implemented; - description of family support programs and efforts to keep the family engaged; - limiting the use of public address and intercom systems for emergencies and evacuation drills	02110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30824	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/07/2021
NAME OF PROVIDER OR SUPPLIER EDGEWOOD HERMANTOWN I SR LVG		STREET ADDRESS, CITY, STATE, ZIP CODE 4195 WESTBERG ROAD DULUTH, MN 55811		
(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
02110	Continued From page 125 only; - transportation coordination and assistance to and fro outside medication appointments; and - safekeeping of resident's possessions. On October 6, 2021, at approximately 10:00 a.m., licensed assisted living director (LALD)-A confirmed the licensee had not developed the policies and procedures and had not given them to the residents. The licensee lacked policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02240 SS=F	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center	02240		

Minnesota Department of Health

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02240	Continued From page 126 (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all residents received the complete new Assisted Living Bill of Rights. This had the potential to affect 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	02240		

Minnesota Department of Health

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02240	Continued From page 127 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1, R3, R4, R2, R5, and R6's records indicated the residents received the new Assisted Living Bill of Rights, but the Bill of Rights did not include the following statement; "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." and the Bill of Rights provided did not include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities and the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. In addition, it did not include a statement that the facility will not retaliate because of a complaint. On October 6, 2021, at approximately 10:00 a.m.,	02240			

Minnesota Department of Health

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02240	Continued From page 128 licensed assisted living director (LALD)-A verified the new Assisted Living Bill of Rights given to R1, R3, R4, R2, R5, and R6 and all other residents receiving services did not include the required content as indicated above. A policy regarding providing residents/representatives the bill of rights and information on complaints was requested from the licensee, but was not provided. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02240			
02310 SS=D	144G.91 Subd. 4 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, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards in two of two rooms (A6 and 121) where oxygen was stored. 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	02310			

Minnesota Department of Health

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02310	Continued From page 129 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). On October 5, 2021, at approximately 2:15 p.m., the engineering team reported they had observed an oxygen tank cylinder lying flat on the floor in resident room 121. On October 5, 2021, at approximately 2:25 p.m., two oxygen tank cylinders were observed in room 121. One oxygen cylinder observed was secured in a wheeled oxygen tank cylinder cart. The second oxygen tank cylinder observed was upright and unsecured. On October 5, 2021, at approximately 2:30 p.m., the engineering team reported they had observed three oxygen cylinders, unsecured, in resident room A6 in the memory care building. On October 6, 2021, at approximately 2:30 p.m., Registered Nurse (RN)-B stated the oxygen tank cylinders should have been stored upright and secured to prevent the cylinders from falling over. The licensee's policy titled, Oxygen Assistance and Administration, dated August 2020, indicated oxygen tanks would be secured and stored upright at all times. The same policy indicated the tanks would have suitable racks or bins for storage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health

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02410	Continued From page 130	02410		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure privacy was maintained during medication administration for two of six residents (R9 and R10) with records reviewed. 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	02410		

Minnesota Department of Health

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02410	Continued From page 131 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: R9 and R10's nasal spray and eye drop medication were administered while R9 and R10 were seated in the dining room at a table occupied by co-residents. R9 R9's prescriber orders dated October 5, 2021, included an order for a nasal spray to be administered to both nostrils daily. On October 5, 2021, at approximately 8:40 a.m., R9 was seated at a dining room table in the open dining/living room area. There were two other residents seated at the same table in the dining room. Unlicensed personnel (ULP)-J approached R9 and following appropriate technique administered a nasal spray medication in direct view of the two other residents seated at the dining table. ULP-J did not encourage, offer, or attempt to assist R9 to a private area prior to administering the nasal spray. R10 R10's prescriber orders dated March 13, 2021, included an order for a nasal spray to be administered to both nostrils daily and eye drops daily. On October 5, 2021, at approximately 8:40 a.m., R10 was seated at a dining room table in the open dining/living room area. There were two other residents seated at the same table in the	02410			

Minnesota Department of Health

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02410	Continued From page 132 dining room. ULP-J approached R10 and following appropriate technique administered a nasal spray medication and administered eye drops to both eyes in direct view of the two other residents seated at the dining table. ULP-J did not encourage, offer, or attempt to assist R10 to a private area prior to administering the nasal spray. Directly following the above two observations, ULP-J confirmed she had not offered, encouraged or provided R9 or R10 privacy when administering nasal sprays and eye drops at the dining room table. On October 5, 2021, at approximately 9:00 a.m., Registered Nurse (RN)-T confirmed nasal spray and eyedrops should be administered in private and not in view of other residents. The licensee's Medication Administration policy dated August 2020 did not address providing privacy during medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		