Electronically Delivered

April 22, 2025

Licensee
Edgewood Baxter LLC
14211 Firewood Drive
Baxter, MN 56425

RE: Project Number(s) SL30293016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 27, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

§ 144G.20.

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

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING

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

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: jessie.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30293	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD BAXTER LLC	14211 FIREWOOD DRIVE BAXTER, MN 56425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30293016 On March 24, 2025, through March 27, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 66 residents; 66 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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 evaluators ' 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 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 24, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to offer meal substitutions of similar nutritional value if a resident refused a food served. In addition, the licensee failed to make menus at least one week in advance available to residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 485		

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0 485	Continued From page 4 The findings include: On March 25, 2025, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-F and ULP-G serving breakfast in the dementia unit. The food items consisted of a waffle, breakfast ham, a bowl of fruit, and beverages. At this time, the surveyor observed the posted menu next to the serving kitchen in the dementia unit for the current week, and behind that was the menu for the previous week. The licensee's Menu Week 3 dated March 23, 2025, through March 29, 2025, included for the breakfast menu on March 25, 2025, a choice of hot or cold cereal and toast in addition to the items observed being served. On March 25, 2025, at 8:10 a.m., ULP-F stated the additional or alternate items were only served in the assisted living, not in the dementia unit. On March 25, 2025, at 2:10 p.m., licensed assisted living director (LALD)-B stated the decision was made to only serve one option in the dementia unit to keep things the same for those residents. In addition, she stated the menu for the coming week was not posted as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or	0 490		

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0 490	Continued From page 5 make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs available to residents. This had the potential to affect all residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 490		

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0 490	Continued From page 6 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 24, 2025, at 10:15 a.m., licensed assisted living director (LALD)-B stated the licensee provided a daily program of social and recreational activity. The licensee's March 2025, Community Calendar for the assisted living and dementia care unit included activities Monday through Friday. However, no activities were listed for Saturday or Sunday. On March 25, 2025, at 2:07 p.m., LALD-B stated no activities were planned on the weekends, and were told they did not have to have them. The licensee's Enrichment Programs, Activities & Outdoor Space policy dated reviewed January 2022, noted "A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
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	0 510		

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0 510	Continued From page 7 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 applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical, and nursing standards for infection control for two of two employees (unlicensed personnel/ULP-G and ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 25, 2025, at 12:00 p.m., the surveyor observed ULP-G bring R1 to her apartment after lunch, put on gloves, wheel R1 to the bathroom, and assist her to the toilet. When R1 was finished, ULP-G removed the brief and placed a clean one, assisted R1 to stand and hold the rail	0 510		

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0 510	Continued From page 8 on the wall, removed the gloves and placed new gloves without performing hand hygiene, touched the walker breaks, pulled up R1's brief and pants, removed the gloves, and assisted R1 to sit in her recliner. At this time, ULP-G reclined the chair using the remote, assisted R1 to scoot back in the chair, and exited the room touching the door, and opening the door to the laundry room to dispose of the trash. At this time, ULP-G asked if she passed, and the surveyor asked when she was trained to perform hand hygiene. ULP-G stated she forgot to bring her small spray bottle of hand sanitizer with her today but always sanitizes when she passes by the sanitizer stations in the hallway. On March 26, 2025, at 7:15 a.m., the surveyor observed ULP-E perform a blood glucose check for R2 in her apartment. With gloved hands, ULP-E wiped R2's right middle finger with an alcohol wipe, poked the finger with a lancet and placed the blood sample on the test strip. Once complete, ULP-E placed the glucometer and supplies in the case, placed the lancet in her gloved hand, exited the room touching the door handle, attempted to open the medication room with the keypad and when unable, grabbed the keys from her pocket and opened the medication room door, placed the lancet in the sharps container, removed the gloves, and washed her hands. At this time, ULP-E stated she washed her hands after doing blood glucose checks in case there was any blood from the procedure. ULP-E stated she did not remove the gloves or perform hand hygiene after performing the task before touching other surfaces because she needed to dispose of the lancet first.	0 510		

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0 510	Continued From page 9 On March 26, 2025, at 2:00 p.m., clinical nurse supervisor (CNS)-A stated staff were trained and expected to perform hand hygiene between dirty and clean tasks such as perineal cares and performing blood glucose tests and after removing gloves. She also stated staff were able to wash their hands in resident apartments and the supplies were provided to do so. The licensee's undated Hand Washing policy noted hand washing would be performed after cleaning up someone who had used the toilet, and before and after treating a cut or wound. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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0 680	Continued From page 10 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 develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. Additionally, the licensee failed to conduct emergency generator inspections at the frequency required. This had the potential to affect residents receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: APPENDIX Z During the facility tour on March 24, 2025, at 10:50 a.m., with registered nurse (RN)-C, the surveyor observed the main entrance with sitting areas and offices. There was an open staircase leading to the second floor. Behind the stairs was a hallway going both ways with resident	0 680		

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0 680	Continued From page 11 apartments and offices. To the left, there was a coded door into the dementia care unit. The upstairs hallway also included resident apartments. The licensee's white binder titled Emergency Operations Program and Plan Manual dated as reviewed on February 2, 2025, did not include: - exercises to test the EP at least twice per year, including unannounced staff drills using the EP to include: - participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise or if the facility experiences an actual emergency requiring activation of the plan, the facility is exempt from engaging in its next required full-scale exercise; - conduct an additional annual exercise that may include a second full-scale exercise that is community based or an individual, facility based functional exercise or mock disaster drill or table-top exercise; and - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events and revise the plan as needed. On March 27, 2025, at 10:20 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated they held missing resident drills quarterly, but did not do the above required drills. The licensee's undated Training and Testing policy noted "Additionally, our facility participates in a Table Top and a Full-Scale Community Exercise if available, annually. If a Full-Scale Community Exercise is not available or feasible, we will document this and conduct a facility-based	0 680		

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0 680	Continued From page 12 exercise instead to test specific aspects of our EOP and identify areas for improvement. Both exercises will follow a formal exercise plan with objectives and a scenario designed to meet those objectives." Per Assisted Living Facilities: Minnesota Rules Chapter 4695, 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. EMERGENCY GENERATOR On March 24, 2025, at 11:45 a.m., the surveyor toured the facility with director of maintenance (DM)-D and LALD-B. During the facility tour, the surveyor observed an emergency power generator. During the facility tour interview, LALD-B verified the emergency power generator was part of the emergency plan. On March 24, 2025, DM-D provided generator inspection and testing records. Emergency generator records indicated the generator was inspected and tested monthly. During an interview on March 24, 2025, at 3:25 p.m., DM-D stated they were not aware weekly generator inspections were required and verified these inspections had not been completed at the required frequency. The licensee failed to meet the minimum	0 680		

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0 680	Continued From page 13 frequency requirements of inspections and testing for the emergency power generator as outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly affect more than a limited number of 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 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).	0 775		

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0 775	Continued From page 14 The findings include: On March 24, 2025, at 11:45 a.m., the surveyor toured the facility with director of maintenance (DM)-D and licensed assisted living director (LALD)-B. During the facility tour, the surveyor observed the following: CARBON MONOXIDE ALARMS/ DETECTION In the assisted living building, carbon monoxide alarms were not installed in resident rooms or in the corridors. During the facility tour interview, DM-D stated there was fuel fired equipment in the assisted living building and a carbon monoxide detector was installed in the mechanical room but no additional carbon monoxide detectors or alarms were installed. Carbon monoxide alarm and detection systems in existing buildings are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511. EMERGENCY LIGHTS The emergency light did not work when tested by DM-D in the corridor outside resident room 219. Emergency lights must be maintained in proper operating condition to illuminate escape routes in the event of a fire or power outage. During the tour interview, DM-D verified the above listed emergency light observation. CONTROLLED EGRESS DOOR SYSTEM PROCEDURES Electromagnetic locks with keypads were installed on emergency exit doors in the dementia care unit. On March 24, 2025, LALD-B and DM-D provided emergency plan procedures. Record review indicated the emergency plan did not include procedures to operate and unlock the electromagnetic controlled locking door system.	0 775		

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0 775	Continued From page 15 During an interview on March 24, 2025, at 3:25 p.m., LALD-(B) verified this information was not included in the plan. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 810 SS=E	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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is	0 810		

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0 810	Continued From page 16 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 record review and interview, the licensee failed to provide required training. This had the potential to directly affect more than a limited number of 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 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 March 24, 2025, licensed assisted living director (LALD)-B and director of maintenance (DM)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. TRAINING Record review indicated the licensee failed to provide fire and evacuation training to residents at least once per year evident by a lack of documentation to support this had been completed. One training record for a gas leak full scale evacuation drill dated October 30, 2024, was provided for review. During an interview on March 24, 2025, at approximately 3:25 p.m., LALD-B stated residents were trained on fire and evacuation procedures when they moved in and then annually. LALD-B verified no additional	0 810		

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0 810	Continued From page 17 training documentation was available to support fire and evacuation training had been completed in the past year with residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and	01060		

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01060	Continued From page 18 designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative for one of one resident (R2) who was hospitalized. 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: R2's diagnoses included vascular dementia. R2's Service Plan dated February 20, 2025, indicated R2 received services including assistance with dressing, hygiene, and medication administration.	01060		

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01060	Continued From page 19 R2's Resident Notes noted R2 was sent to the hospital on February 18, 2025, for unresponsiveness, and returned on February 20, 2025. R2's emergency relocation notice dated February 19, 2025, included the right to appeal. However, it lacked the contact information for the agency to which the resident may submit an appeal. On March 25, 2025, at 3:00 p.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated the emergency relocation template used for all residents did not include the contact information as required. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an open date for three of five residents (R8, R9, R10) with insulin, and failed to monitor for expired medications for one of five	01890		

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01890	Continued From page 20 residents (R8) with insulin. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on March 28, 2025, at 10:15 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents at the facility. On March 26, 2025, at 2:00 p.m., the surveyor observed the licensee's medication carts with CNS-A and noted the following: - R8's Lantus SoloStar insulin pen (prefilled insulin pen) lacked a date when opened; - R8's Humalog KwikPen insulin pen (prefilled insulin pen) was dated opened February 15, 2025, and expiration date of March 15, 2025; - R9's Lantus SoloStar insulin pen lacked a date when opened; and - R10's Lantus SoloStar insulin pen lacked a date when opened. At this time, CNS-A stated the expectation is that all insulin pens are dated with an opened date and expiration date. In addition, CNS-A stated the expired Humalog pen should be discarded after the expiration date. The manufacturer's instructions for use for Lantus	01890		

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01890	Continued From page 21 SoloStar KwikPen dated revised June 2022, noted "Only use your pen for up to 28 days after its first use. Throw away the LANTUS SoloStar pen you are using after 28 days, even if it still has insulin left in it." The manufacturer's instructions for use for Humalog KwikPen dated revised March 2013, instructed "Write down the date you start using your HUMALOG KwikPen. Count forward 28 days. Write down the date you should throw it away." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and	02170		

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02170	Continued From page 22 included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized activity plan based on the evaluation for two of two residents (R1, R2) who resided in an assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: The licensee had an Assisted Living with	02170		

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02170	Continued From page 23 Dementia Care license effective September 1, 2024. R1 R1's diagnoses included Alzheimer's disease. R1's Service Plan dated February 22, 2023, indicated R1 received services including assistance with dressing, hygiene, and medication administration. R1's Assessment dated March 5, 2025, included past and current interests, current abilities and skills, emotional and social needs and patterns, physical abilities and limitations, and adaptations necessary for the resident to participate. However, it lacked an individualized activity plan based on this evaluation. R2 R2's diagnoses included vascular dementia. R2's Service Plan dated February 20, 2025, indicated R2 received services including assistance with dressing, hygiene, and medication administration. On March 25, 2025, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R2 in her room. R2's Assessment dated February 21, 2025, included past and current interests, current abilities and skills, emotional and social needs and patterns, physical abilities and limitations, and adaptations necessary for the resident to participate. However, it lacked an individualized activity plan based on this evaluation. On March 26, 2025, at 2:16 p.m., clinical nurse	02170		

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02170	Continued From page 24 supervisor (CNS)-A stated the goals for residents was similar for all residents, to encourage life enrichment activity participation to prevent isolation and enhance socialization. CNS-A stated an individualized plan had not been developed for any of the residents. The licensee's Enrichment Programs, Activities & Outdoor Space policy dated January 2022, noted "An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's preferences and needs." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop and implement new interventions related to the root cause of falls for one of two residents (R5). In addition, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) with an assistive device.	02310		

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02310	Continued From page 25 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: FALLS R5 R5's admitted on September 23, 2022, and discharged on November 13, 2024. R5's diagnoses included atrial fibrillation (rapid, irregular heartbeat), osteoporosis, hypertension, dementia, and macular degeneration. R5's Service Plan dated October 10, 2024, indicated R5 received services including assistance with dressing, hygiene, and medication administration. R5's Incident Reports included the following: - July 3, 2024 at 6:45 a.m., R5 was found on the floor in her bedroom. R5 stated she was going to the bathroom and hit her head on the chair. R5 was taken to the emergency room by her son. No new interventions implemented; - August 18, 2024, at 6:20 a.m., R5 had a fall in her bedroom and complained of neck, head, and left hip pain. R5 was transferred to the emergency room by ambulance. R5 fractured her hip and returned September 23, 2024, when a full reassessment was completed; - September 24, 2024, at 3:30 p.m., R5 had a fall	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30293	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD BAXTER LLC	14211 FIREWOOD DRIVE BAXTER, MN 56425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 26 in her living room while trying to grab something. Staff posted signs for R5 to call for help; - September 24, 2024, at 5:15 p.m., R5 was found partially on the floor and partially on the end of her recliner. Staff posted signs for R5 to call for help; - September 29, 2024, at 9:30 a.m., R5 was trying to get to the bathroom and slid out of her chair. Interventions included television and coloring for distractions; - September 30, 2024, at 1:54 a.m., R5 was found in her room by the recliner. No new interventions implemented; - October 2, 2024, at 2:00 p.m., R5 had a fall from her recliner. Staff had a care conference to discuss falls and need for a 1:1. R5 was transferred to the dementia care unit the following day; - October 6, 2024, at 6:50 a.m., R5 was found next to her bed, and 30 minute safety checks were implemented; - October 8, 2024, at 2:20 p.m., R5 fell to the floor when trying to get out of her recliner. No new interventions implemented; - October 8, 2024, at 5:10 p.m., R5 fell in her room by the recliner. No new interventions implemented; - October 10, 2024, at 2:30 p.m., R5 fell by the recliner in her room. R5 had medications started for agitation and 1:1 with staff; - October 11, 2024, at 3:30 a.m., R5 fell trying to self transfer from the recliner. No new interventions; - October 12, 2024, at 10:00 a.m., R5 had a fall trying to get out of the recliner to use the bathroom. No new interventions; - October 12, 2024, at 10:00 a.m., R5 had a fall from the recliner. Encourage resident to remain in central location for staff to supervise and requested family assistance with 1:1;	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30293	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEWOOD BAXTER LLC	14211 FIREWOOD DRIVE BAXTER, MN 56425

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02310	Continued From page 27 - October 14, 2024, at 2:00 p.m., R5 fell getting out of the recliner. Elopement and behavior assessment completed. Physical therapy requested the wheels be removed from the bed; - October 23, 2024, at 5:00 p.m., R5 fell independently transferring from the recliner. No new interventions; - October 24, 2024, at 2:00 p.m., R5 had a fall from the recliner. R5 had a medication reconciliation and was seen by the provider on October 25, 2024, when medication adjustments were made and labs were ordered; and - October 31, 2024, at 1:45 a.m., R5 fell outside their apartment. R5 was found sitting in a laundry hamper in the hallway. No new interventions. On March 25, 2025, at 2:30 p.m., clinical nurse supervisor (CNS)-A reviewed the above interventions for each fall. In addition, CNS-A stated at one point, they had a discussion with family about the chair and stated family did not want this removed since it was her long-term chair she was comfortable with. CNS-A stated no new interventions had been implemented related to the chair and falls. ASSISTIVE DEVICE R1 R1's diagnoses included Alzheimer's disease. On March 25, 2025, at 11:15 a.m., the surveyor observed R1's bed with CNS-A. The twin sized bed had a black, upside down U-shaped assistive device on the right side of the bed. The device had four vertical rails between the outside bars. R1's Service Plan dated February 22, 2023, indicated R1 received services including assistance with dressing, hygiene, and medication administration.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30293	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 28 R1's Assessment dated February 21, 2025, lacked information to include: - whether or not the device was securely attached per manufacturer guidelines; - whether the Consumer Product Safety Commission (CPSC) had been checked for a recall on the device; and - resident's preferences. On March 26, 2025, at 2:16 p.m., CNS-A stated R1's assessment lacked the above required content. CNS-A stated the corporate staff checked the CPSC site monthly, but this was not documented. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks);	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30293	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 29 - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". In addition, the MDH website indicated, "licensees should refer to the CSPC for the most up-to-date information related to portable bed side rail recall information." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two unlicensed personnel (ULP)-F followed appropriate medication administration procedures.	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30293	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02320	Continued From page 30 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: R7's diagnoses included asthma and dementia. R7's Service Plan dated March 18, 2025, indicated R7 received services including medication administration. R7's prescriber orders dated March 7, 2025, included ipratropium-albuterol, use via nebulizer three times daily. ULP-F was hired on January 11, 2024, to provide direct care services to residents of the facility. ULP-F's employee record contained a passed Metered Dose Inhaler Medication Competency dated March 21, 2025. On March 25, 2025, at 7:43 a.m., the surveyor observed ULP-F placed the nebulizer medication in the machine, turned it on, and handed it to R7 in his bed. At this time, ULP-F exited the room and stated she leaves R7 to administer it independently and would check back after a few minutes to see if it was done and clean it out. At 8:12 a.m., ULP-F checked on R7 and found it was not completed, and left the room. At 8:20 a.m., ULP-F checked on R7 and determined the nebulizer was complete, removed the mouth	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30293	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02320	Continued From page 31 piece, cleaned it in the kitchen sink, and placed it to dry. On March 25, 2025, at 2:06 p.m., clinical nurse supervisor (CNS)-A stated staff were expected to remain with R7 during the administration of the nebulizer. The licensee's Medication System Summary policy dated January 2025, indicated "Resident self-administration of medication is allowed only when resident had successfully demonstrated safe medication techniques per self-medication assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *03/24/25*
Time: 12:53:43
Report: 1017251048

Food and Beverage Establishment Inspection Report

Location:
Edgewood Baxter Llc
14211 Firewood Drive
Baxter, MN56425
Crow Wing County, 18

Establishment Info:
ID #: 0037700
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188284770
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

PROVIDE THERMOMETER TO ACCURATELY MEASURE MEAT PATTIES AND OTHER THIN MEATS.

Comply By: 04/14/25

6-300 Physical Facility Numbers and Capacities

6-301.12 ***** Priority 2 *****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

GEORGIA PACIFIC PAPER TOWEL DISPENSER LOCATED BY HAND SINK IN MEMORY CARE UNIT WAS OBSERVED EMPTY. TOWELS WERE REPLACED DURING INSPECTION.

Corrected on Site

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Acid: = 700 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Acid: = 700 PPM at Degrees Fahrenheit
Location: 3 COMPARTMENT BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 185 Degrees Fahrenheit - Location: CABAGE LOCATED IN STEAM TABLE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 187 Degrees Fahrenheit - Location: PORK LOCATED IN STEAM TABE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 190 Degrees Fahrenheit - Location: SHEPHERD'S PIE LOCATED IN STEAM TABLE
Violation Issued: No

Process/Item: Cooling
Temperature: 85 Degrees Fahrenheit - Location: SHEPHERD'S PIE LOCATED IN ICE BATH 1 HOUR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: TARTER SAUCE LOCATED IN 2 DOOR UPRIGHT COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: CHEESE LOCATED IN SALAD STATION
Violation Issued: No

Process/Item: Hot Holding
Temperature: 174 Degrees Fahrenheit - Location: VEGETABLE BEEF SOUP LOCATED IN SOUP WARMER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: CUCUMBER SALAD LOCATED IN UPRIGHT BY WIF

Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: MILK LOCATED IN MEMORY CARE SATELLITE KITCHEN
Violation Issued: No

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

DISCUSSION

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG, COOLING TIME AND TEMPERATURE FOR FOOD SAFETY.

Type: Full
Date: *03/24/25*
Time: 12:53:43
Report: 1017251048
Edgewood Baxter Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1017251048 of 03/24/25.

Certified Food Protection Manager: ANLYN D. NOBIS

Certification Number: FM 119508 Expires: 10/23/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
NATE TOPP
PUBLIC HEALTH SANITARIAN
ST. CLOUD
320.223.7333
NATE.TOPP@STATE.MN.US

Report #: 1017251048

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975

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

Date 03/24/25
Time In 12:53:43
Time Out

Edgewood Baxter Llc	Address: 14211 Firewood Drive	City/State: Baxter, MN	Zip Code: 56425	Telephone: 2188284770
License/Permit #: 0037700	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 03/24/25

Inspector (Signature)