Electronically Delivered

August 19, 2024

Licensee
Heritage of Edina Inc
3450 Heritage Drive
Edina, MN 55435

RE: Project Number(s) SL35017015

Dear Licensee:

On July 17, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 4, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Electronically Delivered

May 15, 2024

Licensee
Heritage Of Edina, Inc.
3450 Heritage Drive
Edina, MN 55435

RE: Project Number(s) SL35017015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 4, 2024, 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.

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 . . ."

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

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

The correction order documentation should include the following:

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

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

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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35017	A. BUILDING: _____ B. WING _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE OF EDINA INC	3450 HERITAGE DRIVE EDINA, MN 55435

(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: SL35017015-0 On Apri1 1, 2024, through April 4, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 89 residents, 86 of whom were receiving services under the Assisted Living Facility 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 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, 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 interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. This had the potential to affect residents residing in the facility, 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	0 470		

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0 470	Continued From page 2 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee held an assisted living (ALF) license. The facility was had a current census of 83 residents receiving services. On April 1, 2024, at 10:45 a.m., clinical nurse supervisor (CNS)-B stated the facility developed and implemented a staffing plan and posted a daily staff schedule. CNS-B explained the licensee incorporated three shifts daily to include registered nurses (RN), licensed practical nurses (LPN) and unlicensed personnel (ULP) to provide direct care to residents. On April 1, 2024, at 11:30 a.m., a posted staff schedule was observed near each of two entrances of the facility. The schedule indicated the current date and staff for each shift. On April 2, 2024, at 10:43 a.m., CNS-B provided the licensee's Staffing Plan Meeting sheets which lacked development or implementation of a staffing plan to meet the needs of the residents to include: October 9, 2023, and contained two handwritten notes: -census unchanged -no changes made November 13, 2023, and contained two handwritten notes: -no changes made -staffing stable March 12, 2024, and contained two handwritten	0 470		

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0 470	Continued From page 3 notes: -census unchanged -no changes made in staffing staffing stable The meetings were signed by CNS-B, licensed assisted living director (LALD)-A, assistant director of nursing (ADON)-C, and licensed practical nurse (LPN)-I, who overlooked staff development. The licensee failed to develop and implement a staffing plan for determining its staffing level based on the following: -each resident's needs, as identified in the resident's service plan and assisted living contract. -each resident's acuity level, as determined by the most recent assessment or individualized review. -the ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises; and -whether the facility had a secured dementia care unit; and staff experience, training, and competency. On April 4, 2024, at 12:58 p.m., CNS-B emailed the following, "We've asked HR (human resources) and looked through our papers and we do not have any more regarding staffing minutes than we've already sent you- just the handwritten notes on the meeting pages. We understand we need to improve our procedure to include much more info in our notes." The [licensee name] Staffing and Scheduling policy dated August 21, 2024, indicated the licensee would assure qualified employees would be scheduled to meet operational requirements	0 470		

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0 470	Continued From page 4 and the needs of the residents by adhering to: -the DON/ADON with the assistance of other licensed personnel will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week. -the plan must ensure that staffing levels were adequate to address the following: -each resident's needs, as identified in the resident's service plan and assisted living contract -each resident's acuity level, as determined by the most recent assessment or individualized review -the ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises -whether the facility has a secured dementia No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
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	0 680		

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0 680	Continued From page 5 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff and visitors of the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 April 1, 2024, at 10:45 a.m. during a facility tour of the Rembrandt and Manor campuses, the licensee lacked posting an emergency disaster	0 680		

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0 680	Continued From page 6 plans prominently at either location. On April 1, 2024, at 10:45 a.m., the surveyor requested the licensee's emergency preparedness plan (EPP). Administrator (A)-H stated he had been filling in at the front desk and was unable to locate the facility's EPP. A-H further stated he would check with another staff member and provide the surveyor with the requested EPP. On April 2, 2024, at 9:50 a.m., the surveyor received and reviewed the EPP and content. The licensee's emergency preparedness plan dated April 18, 2023, lacked the following required content: -posting an emergency disaster plan prominently; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations. -subsistence needs for staff and residents during emergency situation; -arrangement with other faculties (including sister facilities); -EP training and testing program; and -annual EP testing requirements. On April 2, 2024, at 10:32 a.m., licensed assisted living director (LALD)-A stated the EPP lacked all the required content noted above. LALD-A further stated she misunderstood what all the requirements were and therefore, did not complete all the EPP requirements. The licensee's Emergency Plan Policies and Procedures policy dated April 18, 2023, indicated the licensee would have an identified emergency plan in place that would be maintained in accordance to state and federal guidelines, to	0 680		

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0 680	Continued From page 7 assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The policy also indicated staff would be trained on the emergency preparedness plan during orientation and annually, emergency and disaster training would be offered to all residents annually, fire drills would be conducted at the residence every other month, including at least two (2) drills for each shift for a total of six (6) fire drills annually, and the results would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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, 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;	0 730		

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0 730	Continued From page 8 (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 record review and interview, the licensee failed to ensure the resident's record included the required content for two of five residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	0 730		

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0 730	Continued From page 9 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 was admitted to the facility June 27, 2022. R1's diagnosis included vascular dementia and hypertension. R1's record lacked a completed, individualized initial review of needs and preferences. R2 was admitted to the facility July 6, 2021. R2's diagnosis included Alzheimer's disease and hypertension. R2's record included the initial RN (registered nurse) assessment was completed on July 20, 2021. The last RN assessment located in R2's record was dated July 7, 2023. On April 2, 2024, at 1:35 p.m. clinical nurse supervisor (CNS-B) explained that although the required content to include R1's needs and preferences and R2's on-going RN assessments were completed as per regulations, the content was not present in either client's chart. CNS-B stated this was something the licensee would work on. The [licensee name] Resident Information and Content policy dated August 1, 2021, indicated accurate and appropriate records for each resident receiving assisted living services would be maintained and include: -current and previous assessments and service plan -all records of communication pertinent to the	0 730		

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0 730	Continued From page 10 resident's services No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 780		

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0 780	Continued From page 11 failed to provide smoke alarms that functioned and are interconnected so that the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On April 04, 2024, at 10:30 a.m., survey staff toured the Manor with maintenance staff (M)-E and the Rembrandt with maintenance staff (M)-D. Survey staff tested the smoke alarms throughout the two buildings. The following was observed in each building. The Manor: 1. Apartment 412 smoke alarm did not work. 2. Apartment 213 did not have a smoke alarm installed. 3. Apartment 112 smoke alarms were not interconnected. The Rembrandt 1. Apartment 216 smoke alarms were not interconnected. These deficient conditions were visually verified by M-D and M-E accompanying on the tour. During interview on April 04 at 3:00 p.m., licensed	0 780		

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0 780	Continued From page 12 assisted living director (LALD)-A stated that they had installed all new smoke alarms, but she did not know why the above-listed locations did not work or were not interconnected. 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 licensee failed to maintain 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. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35017	A. BUILDING: _____ B. WING _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE OF EDINA INC	3450 HERITAGE DRIVE EDINA, MN 55435

(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
0 800	Continued From page 13 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On April 04, 2024, at 10:30 a.m., survey staff toured the Manor with maintenance staff (M)-E and the Rembrandt with maintenance staff (M)-D. The following was observed. The Manor: It was observed that the trash chute door on the fourth floor did not shut and latch on its own. It was observed that the trash chute door on the third floor did not shut and latch on its own. It was observed that the trash chute door on the second floor did not shut and latch on its own. It was observed that the trash chute door on the first floor did not shut and latch on its own. All trash chute doors should close and latch completely to maintain the fire resistance integrity of the trash chute system. It was observed in apartment 303 that the window frame was bent leaving the edge of the glass pane exposed to the inside of the apartment. M-E stated he thought the glass had been recently replaced and the installers must have bent the frame. It was observed that the east exit doors were broken and did not function. M-E stated a resident had broken the doors a few weeks earlier and they were waiting on the replacements. It was observed that the designated smoking area on the patio did not have a non-combustible ashtray for residents to use. Survey staff	0 800		

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0 800	Continued From page 14 explained to M-E that a fire-rated ashtray should be provided for resident use and that the discarded cigarette butts were a potential fire hazard if cigarettes were not completely extinguished before discarding them. The Rembrandt: It was observed that the trash chute door on the fourth floor did not shut and latch on its own. It was observed that the trash chute door on the third floor did not shut and latch on its own. It was observed that the trash chute door on the second floor did not shut and latch on its own. It was observed that the trash chute door on the first floor did not shut and latch on its own. All trash chute doors should close and latch completely to maintain the fire resistance integrity of the trash chute system. It was observed that the ceiling tiles were damaged near the medi-control room on the first floor. It was observed that the carpet transition by apartment 120 was lifting away from the subfloor and was a potential tripping hazard. It was observed that the men's bathroom on the first floor had tiles and base falling off the wall and was cracked in multiple locations. During interview on April 04 at 3:00 p.m., licensed assisted living director (LALD)-A stated she understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 810	Continued From page 15	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 810	Continued From page 16 licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly 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 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 April 4, 2024, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee FSEP, titled "Emergency Plan", dated April 18, 2023, failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. During interview on April 04 at 3:00 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 810	Continued From page 17 Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-A was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. During an interview on April 04, 2024, at 3:00 p.m., LALD-A stated they understood the areas of their training that were insufficient and would work on bringing them into compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical facility elements did not constitute a distinct hazard to life. This had the potential to affect all occupied residents, staff,	0 820		

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0 820	Continued From page 18 and visitors because timely evacuation would not be possible in the event of a fire or other life-threatening emergencies. 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 April 04, 2024, at 10:30 a.m., survey staff toured the Manor with maintenance staff (M)-E and the Rembrandt with maintenance staff (M)-D. The Manor: It was observed that the exit doors at the bottom of the southwest and east exit stairwells did not open when survey staff attempted to open them. M-E opened the doors by pressing down on the panic hardware and kicking them open. Once open, the door did not close and positively latch on its own. M-E had to pull the door shut. All building elements in the path of egress must be properly maintained and in proper working condition. The Rembrandt: It was observed that the second means of egress out of the mechanical room was not labeled and had miscellaneous items stored in front of the door and in the path to the door. Items in storage were obstructing completely the path of egress and the clear floor space required for the egress door. Required clearances must be maintained in	0 820		

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0 820	Continued From page 19 the path of egress to ensure safe exit from the building in the case of an emergency. It was observed that the fourth-floor and second-floor balconies in the lounges were secured with a heavy-duty slide bolt lock on the inside of the door obstructing any residents, visitors, or staff from re-entering the building in an emergency if the lock is engaged. It was observed that the exit door at the bottom of the north exit stair was heavily weathered and did not open when survey staff attempted to open it. M-D opened the door by pressing down on the panic hardware and kicking it open. Once open, the door did not close and positively latch on its own. M-D had to slam the door shut from the outside for the door to close completely and latch. All building elements in the path of egress must be properly maintained and in proper working condition. During interview on April 04 at 3:00 p.m., with licensed assisted living director (LALD)-A, survey staff explained to LALD-A that the slide bolt lock in the path of egress from the balconies would cause a delay in the proper exiting of the space during a fire or similar emergency. It could also be used to trap a person outside on the balcony. Unobstructed egress from the balcony must be maintained. LALD-A stated she would get the slide bolt locks removed that same day. LALD-A also stated she understood the requirements for maintaining the path of egress from high-hazard spaces and the exit stairwells. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (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.	01060		

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01060	Continued From page 21 (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, or designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R6). 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's Current Resident Roster identified R6's date of admission was December 11, 2012, and date of emergency transfer to a local hospital for evaluation was March 26, 2024. As of the start date of the survey (April 1, 2024), R6 had not returned to the licensee. R6's Resident Notes/Fall Reports dated March 26, 2024, through April 3, 2024, included in R6's record were as follows: - March 26, 2024, at 5:00 a.m., indicated R6 lost	01060		

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01060	Continued From page 22 her balance and ended up on the floor; - March 26, 2024, at approximately 5:40 a.m., emergency medical services (EMS) were contacted and R6 was transported to the hospital; - March 26, 2024, at 10:25 a.m., indicated R6 was admitted to the hospital; and - April 3, 2024, at 2:30 p.m., indicated relocation notification was faxed to OOLTC (the survey began on April 1, 2024). R6's record lacked documentation the licensee provided the resident, legal representative, or designated representative a written notice when R6 required emergency relocation and had not returned to the facility within four days that contained the following information: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal; - provide contact information for the agency to which the resident may submit an appeal to the resident, legal representative, and designated representative; and - the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. R6's record included a notification to the OOLTC dated April 3, 2024, at 2:30 p.m., which was four days past the required notice to the OOLTC, when the resident did not return from the	01060		

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01060	Continued From page 23 emergency relocation within four days. On April 2, 2024, at 12:30 p.m., licensed assisted living director (LALD)-A indicated the licensee had been in touch with R6's social worker, hospital discharge planner, Bluestone physicians, and R6's power of attorney. LALD-A stated the licensee did not issue a written notice that contained all the required elements noted above to R6, R6's legal representative, or the OOLTC within four days of R6 not returning to the facility. LALD-A further stated not being aware of the requirement. The licensee's Emergency Relocation policy dated April 3, 2024, indicated in the event of an emergency relocation, licensee would provide a written notice that contained, at a minimum: - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident had the right to appeal; - contact information for the agency to which the resident may submit an appeal; - the notice required would be delivered as soon as practicable to the resident, legal representative, and designated representative, and for residents who received home and community-based waiver services, the resident's case manager; and - the Office of Ombudsman for Long-Term Care if the resident had been relocated and had not returned to the facility within four days. No further information was provided.	01060		

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01060	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164
651-201-4500

Type: Full
Date: *04/02/24*
Time: 15:55:57
Report: 7963241041

Food and Beverage Establishment Inspection Report

Location:

Heritage Of Edina Inc
3450 Heritage Drive
Edina, MN55435
Hennepin County, 27

Establishment Info:

ID #: 0037756
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529209145
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: REMBRANDT SANI DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 36 Degrees Fahrenheit - Location: MANOR KITCHEN
Violation Issued: No

Process/Item: CUT WATERMELON
Temperature: 37 Degrees Fahrenheit - Location: MANOR KITCHEN
Violation Issued: No

Process/Item: CR OF POTATO SOUP
Temperature: 141 Degrees Fahrenheit - Location: MANOR KITCHEN
Violation Issued: No

Process/Item: SLOPPY JOES
Temperature: 146 Degrees Fahrenheit - Location: MANOR KITCHEN
Violation Issued: No

Process/Item: MILK
Temperature: 37 Degrees Fahrenheit - Location: REMBRANDT KITCHEN
Violation Issued: No

Process/Item: HAM
Temperature: 38 Degrees Fahrenheit - Location: REMBRANDT KITCHEN
Violation Issued: No

Type: Full
Date: *04/02/24*
Time: 15:55:57
Report: 7963241041
Heritage Of Edina Inc

Food and Beverage Establishment Inspection Report

Process/Item: HOT DOG
Temperature: 38 Degrees Fahrenheit - Location: REMBRANDT KITCHEN
Violation Issued: No

Process/Item: PORK CHOP
Temperature: 196 Degrees Fahrenheit - Location: REMBRANDT HOT HOLDING
Violation Issued: No

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

MET WITH HRD NURSE SURVEYOR MARY BRUESS, DIRECTOR PATTY SHUMAKER AND FOODSERVICE MANAGER PREETHA KURIAN.

DISCUSSED THE FOLLOWING-

-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-HIGHLY SUSCEPTIBLE POPULATION REQUIREMENTS

THIS CAMPUS HAS THREE BUILDINGS WITH TWO SEPARATE LICENSES. REMBRANDT AND MANOR ON ONE LICENSE AND TIFFANY ON THE OTHER. REMBRANDT AND MANOR WERE INSPECTED TODAY.
REMBRANDT HOUSES THE MAIN KITCHEN AND MANOR HAS A SERVICE KITCHEN.
DISHWASHING FOR MANOR IS DONE AT THE TIFFANY BUILDING.

ALL THREE BUILDINGS HAVE COMMERCIAL FOOD SERVICE SPACES.

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 7963241041 of 04/02/24.

Certified Food Protection Manager: Preetha Kurian

Certification Number: FM 10010 Expires: 06/16/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Preetha Kurian

Signed: Peggy Spadafore
Peggy Spadafore
Sanitarian Supervisor
metro
651-201-4500
peggy.spadafore@state.mn.us

Report #: 7963241041

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools and Lodging Services Section
625 N Robert St
St Paul, MN 55164

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

Date 04/02/24
Time In 15:55:57
Time Out

	Address	City/State	Zip Code	Telephone
Heritage Of Edina Inc	3450 Heritage Drive	Edina, MN	55435	9529209145

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037756		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 04/05/24

Inspector (Signature) Peggy Spudy