DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 27, 2023

Licensee
Cardigan Ridge Senior Living
3300 Rice Street
Shoreview, MN 55126

RE: Project Number(s) SL33082015

Dear Licensee:

On July 26, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the June 16, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

July 14, 2023

Licensee
Cardigan Ridge Senior Living
3300 Rice Street
Shoreview, MN 55126

RE: Project Number(s) SL33082015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 16, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and

submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

REQUESTING A HEARING

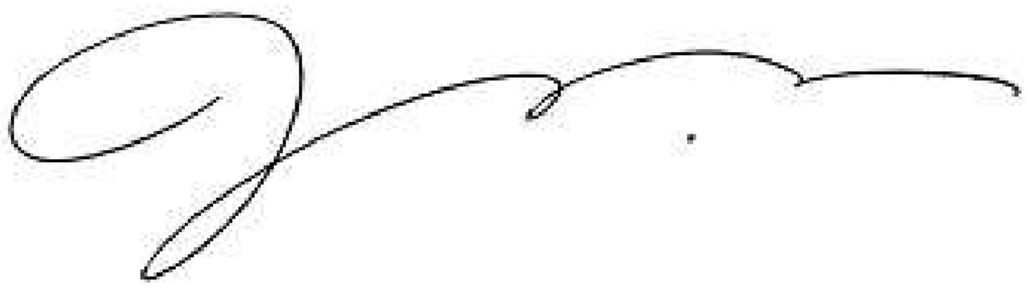
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH 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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

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

If you have any questions, please contact me.

Sincerely,



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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33082	A. BUILDING: _____ B. WING _____	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDIGAN RIDGE SENIOR LIVING	3300 RICE STREET SHOREVIEW, MN 55126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL33082015-0 On June 12, 2023, through June 16, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 117 active residents; 70 receiving services under the Assisted Living with Dementia Care license. The immediacy of order 2310 was removed on June 14, 2023, based on supervisor review, however, the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 12, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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	0 800		

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0 800	Continued From page 2 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 of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 14, 2023, approximately from 11:00 a.m. to 2:30 p.m., survey staff toured the facility with the director of maintenance (DOM)-F. During the tour, survey staff observed the following: - The memory care laundry room fire-rated door was wedged in the open position using a trash bin preventing the door from closing and maintaining the fire rating of the room. In addition, the wedged door posed concerns of memory care resident access from misuse of chemicals/detergents used/stored in the laundry room. - The north mechanical room had compromised ceiling penetration consisting of approximately 12-inch by 12-inch size opening that had not been patched from recent work.	0 800		

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0 800	Continued From page 3 -Inside resident rooms 428 and 332, the toilet water supply fittings needed to be repaired to prevent leaks and for proper flushing of the toilets. A plastic bucket was placed under the water supply fitting for the toilet in room 332. The DOM-F verified the findings and stated that he will take care of the repairs. -The 3rd and 4th-floor fire barrier doors failed to close and latch when released to provide proper smoke compartmentation protection during a fire. -One of the two fire-rated doors between the dining room and the elevator lobby failed to close when released to provide fire compartment protection. The finding was evident as there was a missing door closer hardware on one of the doors. Fire-rated doors must properly maintain to protect and maintain the fire separation. The findings were visually verified by the DOM-F accompanying the tour. On June 14, 2023, at approximately 3:15 p.m., during the exit interview, the licensed assisted living director-A and the DOM-F acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms;	0 810		

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0 810	Continued From page 4 (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 record review and interview, the licensee failed to provide complete content of the fire safety and evacuation plan, required training on the fire safety and evacuation plan, and the minimum employee evacuation drills. This has the potential to directly affect the safety of all residents receiving services, staff, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 5 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 14, 2023, approximately from 11:00 a.m. to 2:15 p.m., survey staff toured the facility with the director of maintenance (DOM)-F. On June 14, 2023, at approximately 2:15 p.m., survey staff requested and was provided documentation, dated January 2023, Assisted Living Disaster and Emergency Plan (EP) binder and related documentation for review from the DOM-F. At approximately 3:00 p.m., document review and interview were performed with the licensed assisted living director (LALD)-A and the DOM-F indicated the following: -Documentation review indicated the licensee did not have a fire safety plan that include employee fire safety procedures in the EP binder provided for review. EP binder was provided for review but did not include the employee fire safety procedures. During the interview, survey staff asked the LALD-A and she confirmed the finding as there was no fire safety plan in the binder provided or available for review. -Documentation review indicated the licensee did not provide the required 2022 annual training to residents who can assist in their evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation. The documentation was requested and received on 5/15/2023 but no record was provided or	0 810		

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0 810	Continued From page 6 available for review for the year 2022. -Documentation review indicated the licensee lacked employee training on fire safety and evacuation plan for review. The facility's policy (dated 1/5/2023) had the correct policy on the frequency of employee training on fire safety and evacuation plans but no record was provided or available for review. -Record review indicated the licensee lacked the minimum required employee evacuation drills. Survey staff requested and received one record dated May 30, 2023, for the burned toast incident documentation for the memory care part of the facility. Survey staff explained that the licensee must perform the minimum frequency of evacuation drills twice per year per shift with at least one evacuation every other month, totaling six evacuation drills per year to meet the requirement. On June 14, 2023, at approximately 3:15 p.m., during the exit interview, the LALD-A and the DOM-F acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) 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,	01060		

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01060	Continued From page 7 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. (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	01060		

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01060	Continued From page 8 the resident, legal representative, or designated representative, for two of two residents (R6, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R6 R6 was admitted to the licensee on June 1, 2021, for assisted living services. R6's nursing progress note dated January 24, 2023, at 10:17 a.m., indicated R6 was taken to the hospital by family while out on leave of absence, the hospital recommended R6 transfer to a transitional care unit, and R7 remained out of the facility for a total of 37 days. R6's records lacked evidence the licensee updated the Office of Ombudsman for Long-Term Care after the resident had been relocated and had not returned to the facility within four days. R7 R7 was admitted to the licensee on January 27, 2022, for assisted living services. R7's nursing progress note dated May 29, 2023, at 11:39 a.m., indicated R7's son had called 911 and R7 was transferred to the hospital by ambulance and remained out of the facility for 11 days following a diagnosis of aspiration pneumonia.	01060		

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01060	Continued From page 9 R7's records lacked evidence the licensee updated the Office of Ombudsman for Long-Term Care after the resident had been relocated and had not returned to the facility within four days. On June 14, 2023, at 10:20 a.m., clinical nurse supervisor (CNS)-B stated at the time of R6's emergency relocation they were unaware of the emergency relocation form requirement or the need to update the Ombudsman. CNS-B stated they had started using an emergency relocation form and had a form to send to the Ombudsman if the resident was gone for more than four days. CNS-B supplied an emergency relocation form and the Ombudsman notification form. The relocation form lacked all the contact information for the location to which the resident had been relocated, contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and evidence the form was delivered to the resident, legal representative, and designated representative as soon as practicable. The notification to the Office of Ombudsman notification lacked evidence it had been sent. CNS-B stated they were unaware of all the required emergency relocation requirements. The licensee's Emergency Relocation policy dated July 29, 2021, indicates "[Licensee] 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". "In the event of an emergency relocation, [licensee] will provide a written notice that contains the minimum:	01060		

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01060	Continued From page 10 a. The reason for the relocation. b. The name and contact information for the location to which the resident has been relocated and any new service provider. c. Contact information for the Office of Ombudsman for Long-Term Care and Office of Ombudsman for Mental Health and Developmental Disabilities. d. 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 noy currently known, and e. A statement that, if the facility refuses to provide housing or services after relocation, the resident has the right to appeal." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01470		

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01470	Continued From page 11 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470		

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01470	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for three of three employees (unlicensed personnel (ULP)-C, ULP-D, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C began employment with the licensee March 14, 2022, to provide assisted living services to the licensee's residents. ULP-D ULP-D began employment with the licensee June 1, 2021, to provide assisted living services to the licensee's residents. ULP-E ULP-E began employment with the licensee March 28, 2022, to provide assisted living services to the licensee's residents. ULP-C, ULP-D and ULP-E's employee records lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following:	01470		

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01470	Continued From page 13 --review of provider's policies and procedures. On Tuesday, June 13, 2023, from 8:15 a.m. through 11:45 a.m., the surveyor observed ULP-D serve breakfast, provide cares, administer medications, and use mechanical lifts with R2 and R3. On Tuesday, June 13, 2023, at 10:15 a.m., the surveyor observed ULP-C and ULP-E use an EZ stand lift with R5 and assist R5 with toileting. On June 13, 2023, at 12:30 p.m., clinical nurse supervisor (CNS)-B stated, she was unaware of why ULP-C did not receive all of her new hire training before working on the floor with residents. CNS-B went to get licensed assisted living director (LALD)-A for more clarification. On June 13, 2023, at 12:40 p.m., LALD-A stated, licensee did not have the new hire orientation paperwork for ULP-D because the building used to be owned by another company and all the new hire training was completed through them. Previous owners did not leave the new hire paperwork when ownership changed hands. LALD-A stated new hire training was not completed by current licensee at the time they took over. LALD-A stated if surveyors looked at more employee records, surveyors would find issues with all employees who worked here prior to the change of ownership, and all employees would be lacking required training records. LALD-A further stated that current new hire orientation does not include the training of policies and procedures, but they would be adding that. LALD-A stated surveyors would find all employees to lack training on the licensee's policies and procedures.	01470		

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01470	Continued From page 14 The licensee's Orientation of Staff and Supervisors & Content policy dated August 1, 2021, indicated, all staff providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01490 SS=D	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required dementia care training was completed for one of three employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01490		

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01490	Continued From page 15 ULP-D started employment on June 1, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-D's employee record lacked evidence of at least eight hours of initial dementia training within 80 working hours of the employment start date to include: (1) an explanation of Alzheimer's disease and other dementias; and (2) assistance with activities of daily living; and (3) problem solving with challenging behaviors; and (4) communication skills; and (5) person-centered planning and service delivery. On June 13, 2023, at 2:45 p.m., licensed assisted living director (LALD)-A stated the employee record was missing the required dementia care training. LALD-A further states the final audit of orientation completion was in the heath unit coordinator (HUC)-G's job duty responsibility, and they will be changing that process to include an easier tracking system to maintain training is completed upon hire before taking care of any residents. The licensee's Dementia Training policy, dated August 1, 2021, indicated the missing dementia training topics above should be completed within 80 hours of employment start date for direct care employees. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01490		

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01500	Continued From page 16	01500		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500		

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01500	Continued From page 17 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for three of three employees (unlicensed personnel (ULP)-C, ULP-D, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C started employment with licensee March 14, 2022.	01500		

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01500	Continued From page 18 ULP-C's employee record had a total of 6.75 hours of dementia annual training, and zero of the required eight hours of annual training for each 12 months of employment. ULP-D's record lacked the following topics: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights; (3) review of infection control techniques; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors; (5) review of the facility's policies and procedures; and (6) the principles of person-centered planning. ULP-D started employment with licensee June 1, 2021. ULP-D's employee record had a total of 7 hours of annual training for the past 12 months of employment. ULP-D's record lacked the following required topic: (1) review of the facility's policies and procedures. ULP-E started employment with licensee March 28, 2022. ULP-E's employee record had a total of 2 hours of dementia annual training, and zero of the required eight hours of annual training for each 12 months of employment. ULP-E's record lacked the following topics: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights; (3) review of infection control techniques; (4) effective approaches to use to problem solve when working with a resident's challenging	01500		

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01500	Continued From page 19 behaviors; (5) review of the facility's policies and procedures; and (6) the principles of person-centered planning. On June 13, 2023, at 1:20 p.m., assisted living director (LALD)-A stated the health unit coordinator (HUC)-G enters employees into the Educare (online training platform) system and assigns annual training modules. On June 13, 2023, at 1:45 p.m., LALD-A brought HUC-G to explain the new orientation process. HUC-G stated she does assign all annual training, but this has not included review of the facility's policies and procedures. HUC-G stated she was not aware this was a required course but does not follow up on who does not complete required courses. LALD-A stated this is a systemic issue and because no one is following up on what is completed, she does not know how many employees would not have completed all the required annual training. LALD-A stated licensee would be updating their process to include running a report on which employees need to complete annual training and pull them off the floor until it is complete. Licensee's Annual Required Staff Training policy dated August 1, 2021, indicated "all staff that perform direct care services at [licensee] will complete at least 8 hours of annual training for each 12 months of employment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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01620	Continued From page 20	01620		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive nursing assessment within the required 90-day timeframe for two of five residents (R4, R5). 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	01620		

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01620	Continued From page 21 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: R4 R4's diagnoses included but were not limited to diabetes-type II, cerebral vascular accident, and chest pain. R4's service plan dated May 3, 2023, indicated R4 received services which included medication administration, blood glucose monitoring, medication set-up, assistance with bathing, grooming, dressing, toileting, and housekeeping/laundry. On June 13, 2023, at 11:30 a.m., unlicensed personnel (ULP)-H was observed to provide direct care services to R4 which included medication administration. R4's record included a Universal Assessment Tool for a 90-day visit dated December 6, 2022. However, lacked documentation of ongoing 90-day reassessments as required and the following 90-day assessment was not completed until March 10, 2023 (four days overdue). R5 R5's diagnoses included but were not limited to acute bronchitis, diabetes-type II, morbid obesity, and essential hypertension. R5's service plan dated January 30, 2023,	01620		

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01620	Continued From page 22 indicated R5 received services which included medication administration, assistance with whirlpool, dressing, toileting, transfer assist with an EZ Stand (type of standing lift for transfers), and housekeeping/laundry. On June 13, 2023, at 10:15 a.m., ULP-C and ULP-E were observed to provide direct care services to R5 which included transfer assist with the EZ Stand and toileting assistance. R5's record included a Universal Assessment Tool for a 90-day visit dated October 5, 2022. However, lacked documentation of ongoing 90-day reassessments as required and the following 90-day assessment was not completed until January 30, 2023 (27 days overdue). On June 14, 2023, at 11:00 a.m., clinical nurse supervisor (CNS)-B stated some of the assessments were out of compliance. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated February 11, 2022, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident assessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup	01770		

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01770	Continued From page 23 Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on June 12, 2023, at 10:35 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication set up for some of their residents. R4's diagnoses included but were not limited to diabetes-type II, cerebral vascular accident, and chest pain. R4's service plan dated May 3, 2023, indicated R4 received services which included medication administration, medication set-up, blood glucose monitoring, assistance with bathing, grooming, dressing, toileting, and housekeeping/laundry.	01770		

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01770	Continued From page 24 R4's prescriber orders dated May 25, 2023, indicated that most of R4's medications were given from a medication planner. On June 13, 2023, at 11:30 a.m., the evaluator observed unlicensed personnel (ULP)-H administer medications to R4 from a medication planner. R4's record contained a progress note dated June 13, 2023, at 10:07 a.m., that stated medication set-up completed today and was signed by the registered nurse. R4's record lacked all the required documentation for medication setup that included the name of the medications, quantity of dose, times medications are to be administered, and route of administration. On June 13, 2023, at 1:20 p.m., CNS-B stated the provided progress note was the only documentation the licensee has for medication set-ups. CNS-B stated this was the process the nurse uses to complete medications set-ups for all residents receiving this service. The licensee's 7.09 Medication Management - Dosage Box Setup policy dated January 12, 2022, indicated a licensed nurse will assure the medication orders are transcribed into the medication administration record. This profile includes: -dates of medication set up; -medication name; -quantity of dose; -times to be administered; -route of administration; -name of the person completing the medication set up; -visual description of medication; and	01770		

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	33082	A. BUILDING: _____ B. WING _____	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDIGAN RIDGE SENIOR LIVING	3300 RICE STREET SHOREVIEW, MN 55126

(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
01770	Continued From page 25 -drug classification and special precautions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for two of seven residents (R2, R3). In addition, the licensee failed to ensure the medication refrigerator maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	01880		

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01880	Continued From page 26 UNSECURED MEDICATIONS R2 R2 admitted to licensee November 23, 2022, and started receiving assisted living services. R2's unsigned service plan dated November 22, 2022, indicated R2 received 90 day assessments, catheter care, Hoyer transfers, assistance with dressing for morning and night, set up to eat, escorts to and from meals, twice daily foot care with lotion, grooming assistance, assistance to get in the chair every morning, incontinence care, medication administration, repositioning, toileting, twice weekly showers, daily vital signs, hospice care, and use of wheelchair. R2's Medication Management Plan dated November 22, 2022, indicated medications would be securely stored by the provider in a locked central location. R2's Universal Assessment Tool dated May 22, 2023, indicated staff administered all medications. On June 13, 2023, at 9:30 a.m., the surveyor observed unlicensed personnel (ULP)-D complete the medication pass for R2, shower and catheter care. During observations surveyor noticed Phytoplex silicone Cream Moisture and zinc cream on the bathroom counter unlocked and unsecure. R3 R3 admitted to licensee June 1, 2021, under the former comprehensive license and started receiving assisted living services August 1, 2021. R3's unsigned service plan dated June 26, 2023,	01880		

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01880	Continued From page 27 indicated R3 received 90 days assessment, toileting, denture application and removal, laundry, medication administration, escorts to and from all meals, safety checks, three times a week shower assistance, transfer assistance with EZ stand, and monthly vital signs. R3's Medication Management Plan dated May 11, 2023, indicated medications would be securely stored by the provider in a locked central location. R3's Universal Assessment Tool dated April 20, 2023, indicated staff administered all medications. On June 13, 2023, at 8:15 a.m., surveyor observed ULP-D assist with R3's morning cares and medication pass. Surveyor observed triple antibiotic ointment and bacitracin ointment on the bathroom counter not locked or secured. On June 13, 2023, at 9:45 a.m., ULP-D stated employees in the memory care unit keep creams and powders at the bedside for convenience. On June 13, 2023, at 10:15 a.m., clinical nurse supervisor (CNS)-B stated medications were stored in a locked medication cart and never to be left at the bedside in memory care. MEDICATION REFRIGERATOR On June 12, 2023, at 1:45 p.m., the surveyor observed the medication refrigerator located in the unlicensed staff office on the unlocked unit with unlicensed staff (ULP)-C. The surveyor observed a temperature log located on top of the refrigerator that contained sporadic temperature readings and some readings that were logged that were over the recommended range.	01880		

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	33082	A. BUILDING: _____ B. WING _____	06/16/2023

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01880	Continued From page 28 The temperature log dated April 6, 2023, through June 12, 2023, indicated the following: -April 6-30, 2023, contained 10 of possible 25 temperatures that were not recorded and had 7 of the 10 recordings where the temperature was not in between 36-46 degrees Fahrenheit; and -May 1-31, 2023, contained 4 of possible 31 temperatures that were not recorded and had 2 of the 4 recordings where the temperature was not in between 36-46 degrees F; and -June 1-12, 2023, contained 2 of possible 12 temperatures that were not recorded and had 2 of the 2 recordings where the temperature was not in between 36-46 degrees F. The refrigerator contained the following medication: - 1 unopened Lantus 100 units/ml insulin pen; - 1 unopened Bydureon BCise 2 mg (injectable diabetes medication) pen; - 6 unopened Novolog Flex insulin pens 100 u/ml (rapid acting insulin); - 2 unopened Trulicity injection pen 0.75 mg (non-insulin injection to treat diabetes); and - 3 unopened Skyrizi injection pen 150mg/ml (non-insulin injection to treat psoriasis). The manufacturer's instructions for Lantus insulin pens dated August 2022, indicated unopened insulin pens should be stored in the refrigerator (36 to 46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Bydureon BCise last revised December 2022, indicated to store unopened pens in a refrigerator in between 36-46ºF. The manufacturer's instructions for Trulicity injection pen revised December 2022, indicated	01880		

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01880	Continued From page 29 to store unopened Trulicity in the refrigerator at 36-46 degrees F and do not freeze. The manufacturer's instructions for Novolog insulin pen dated February 2023, indicated to store unopened Novolog in the refrigerator at 36-46 degrees F and do not freeze. The manufacturer's instructions for Skyrizi injection pen revised March 2023, indicated to store Skyrizi in the refrigerator between 3636-46 degrees F. On June 12, 2023, at 1:45 p.m., ULP-C stated she thinks the temperature should be recorded daily. On June 12, 2023, at 3:20 p.m., CNS-B stated the only temperature log they had was the one that was located on the top of the medication refrigerator. CNS-B stated the temperature log showed that the temperature was not being documented daily as required and confirmed some of the temperatures were not in the recommended temperature range. The licensee's Medication Storage policy dated August 1, 2021, indicated when medications are managed and stored by the licensee, medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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02040	Continued From page 30	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to develop a memory care site-specific safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect memory care residents from harm. This has the potential to directly affect staff and all memory care residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to 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 clients). The findings include: On June 14, 2023, approximately from 11:00 a.m.	02040		

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02040	Continued From page 31 to 2:15 p.m., survey staff toured the facility with the director of maintenance (DOM)-F. On June 14, 2023, at approximately 3:00 p.m., a documentation review and interview were performed with the licensed assisted living director (LALD)-A and the DOM-F relating to the memory care site-specific safety risk/vulnerability assessment and mitigation plan which indicated the licensee lacked memory care site-specific safety risk assessment and mitigation plan to identify vulnerabilities and mitigations on and around the property to protect the memory care residents from harm. This finding was evident as the documentation provided for the review was an all-hazard risk assessment as part of an emergency preparedness plan documentation that was provided for review. The findings were confirmed during the interview with the LALD-A and the DOM-F that the licensee lacked the memory care site-specific provisions. On June 14, 2023, at approximately 3:15 p.m., during the exit interview, LALD-A and DOM-F acknowledged the above findings. During the exit interview survey staff discussed the findings and explained that all potential safety risks and/or vulnerabilities site-specific to memory care residents on and around the property including air conditioning fan units located on the memory care patios, toasters in the common kitchenette areas, elopement risks, cleaning chemicals, small appliances, and any other risks need to be identified, assessed, and mitigated and be documented in the plan to protect the memory care residents from harm. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	02040		

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02040	Continued From page 32 (21) days	02040		
02310 SS=G	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 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 (R4) with an assistive device (consumer side rail). This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: On June 13. 2023 at 10:30 a.m., the surveyor observed R4's consumer side rail which was on the left side of the bed and was a large u-shaped bar with two legs that fit underneath the mattress. The surveyor pulled outward on the side rail to check if it was securely attached and was able to pull the whole side rail from underneath the bed	02310		

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02310	Continued From page 33 with minimal effort. The side rail was not secured to the bed or bed frame. A sticker adhered to R4's side rail indicated the manufacturer was Bed Handles, Inc., and the model number was BA10W. R4's diagnoses included diabetes type II and history of cerebrovascular accident (stroke). R4's Vulnerability Assessment dated March 10, 2023, indicated a vulnerability included having a side rail. R4's assessment indicated the goal of the side rail was to improve R4's ability in bed mobility and positioning. The assessment also indicated R4 would remain free from injury and the side rail will remain in proper working order. R4's Side Rail Use Assessment Form dated March 21, 2023, indicated R4 had alteration in safety awareness due to cognitive decline, history of falls, poor bed mobility, had difficulty with balance and trunk control, and was visually challenged. The assessment indicated R4 was able to demonstrate safe and proper use of the side rail. The assessment indicated R4 had a side rail on the left side of the bed utilized to get in and out of bed and to help in positioning. The assessment indicated the risk versus benefits were discussed with resident and family, and the form was emailed to R4's responsible party but the licensee never received a signed copy back. R4's Master Assessment dated May 2, 2023, indicated R4 was independent with getting out of bed and used a half bed rail as a resource to get in and out of bed. R4's Attachment E service plan dated May 3, 2023, indicated services including medication administration, toileting, assistance with morning	02310		

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02310	Continued From page 34 and evening dressing, diabetes management, and showers. R4's record lacked: " Condition and description (i.e., an area large enough for a resident to become entrapped) of the side rail; " Installation and use according to manufacturer's guidelines; " Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; " Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements; and " Documentation the licensee reviewed the United States Consumer Product Safety Commission (CPSC) website for portable side rail recalls. On June 13, 2023, at 1:30 p.m., clinical nurse supervisor (CNS)-B stated they were unable to find the manufacturer's instructions for the bed rail and was unaware the bed rail had been recalled. A CPSC news release "CPSC Warns Consumers to Stop Use of Three Models of Adult Portable Bed Rails Manufactured by Bed Handles, Inc., Due to Entrapment, Asphyxia Hazard" dated April 21, 2021, indicated "The [CPSC] is warning consumers to immediately stop using three models of adult portable bed rails manufactured by Bed Handles, Inc. These models (AJ1, BA10W, and BA11W) can create an entrapment hazard and pose a risk of asphyxia to users. Because the manufacturer of these bed rails is no longer in business, the company cannot offer a remedy. Consumers are urged to immediately stop use of the products and dispose of the	02310		

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02310	Continued From page 35 products." The licensee's 6.28 Side Rail policy effective/revised date of April 14, 2023, indicated the licensee will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of safe design and utilized consistent with the manufacturer's directions. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated April 25, 2023, indicated, "Licensees should review the CSPC website regularly for updates on recalled portable bed rails. The opportune time to do this would be with the 90-day assessment due to the requirement included in the uniform assessment tool for assessing assistive devices." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of order 2310 was removed on June 14, 2023, based on supervisor review, however, the scope and level remain unchanged.	02310		

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

Type: Full
Date: *06/12/23*
Time: 12:30:00
Report: 1025231136

Food and Beverage Establishment Inspection Report

Location:
Cardigan Ridge Senior Living
3300 Rice Street
Little Canada, MN55126
Ramsey County, 62

Establishment Info:
ID #: 0038903
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6514848484
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.

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Breakfast display cooler does not appear to meet above requirements for holding TCS foods (milk). Monitor temperatures of TCS items; if the cooler fails to hold TCS foods at or below 41 deg F, replace with a cooler that meets the above requirements.

Comply By: 06/12/23

Surface and Equipment Sanitizers

Hot Water: = at 162 Degrees Fahrenheit
Location: 155 W 185 R 15 PSI
Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: 3 compartments sink Red sanitary bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: HB egg
Temperature: 41 Degrees Fahrenheit - Location: Walk-in cooler
Violation Issued: No

Process/Item: Milk
Temperature: 45 Degrees Fahrenheit - Location: Breakfast display cooler, cooling from ambient
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Deli turkey
Temperature: 41 Degrees Fahrenheit - Location: Prep line
Violation Issued: No

Process/Item: Cut melon
Temperature: 41 Degrees Fahrenheit - Location: Undercounter prep line
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Memory care North cooler
Violation Issued: No

Process/Item: Milk
Temperature: 42 Degrees Fahrenheit - Location: Memory care South cooler
Violation Issued: No

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

Prep sink serviced during inspection
Memory care units rinse and return items to kitchen. Designate one side of the sink for handwashing, the other for warewashing (label both sides to prevent confusion/cross contamination, handwashing signs are posted)
Discussed health and employee hygiene, illness reporting and exclusion; no large portions reported routinely cooled; suppliers, recalls, and foods for highly susceptible populations; facilities, receiving, and pest control; alternative meals and allergies.

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 1025231136 of 06/12/23.

Certified Food Protection Manager: Fikreta Okanovic

Certification Number: FM40353 Expires: 03/02/26

Inspection report reviewed with person in charge and emailed.

Signed: FIKRETA
Establishment Representative

Signed: Casey Kipping

Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025231136

Food Establishment Inspection Report

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

No. of RF/PHI Categories Out	0	Date	06/12/23
No. of Repeat RF/PHI Categories Out	0	Time In	12:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

Cardigan Ridge Senior Living	Address: 3300 Rice Street	City/State: Little Canada, MN	Zip Code: 55126	Telephone: 6514848484
License/Permit #: 0038903	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
	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

		Safe Food and Water	COS	R
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		

		Proper Use of Utensils	COS	R
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	X	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) F IKRPAO **Date:** 06/12/23

Inspector (Signature) Cory Kim