Electronically Delivered

October 17, 2025

Licensee
Ridgeview Senior Living
1009 10th Avenue Northeast
Saint Joseph, MN 56374

RE: Project Number(s) SL20619016

Dear Licensee:

On August 1, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on April 23, 2025. 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,

Benjamin Zwart

Benjamin J. Zwart, Supervisor
State Evaluation Team
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH

Electronically Delivered

May 30, 2025

Licensee
Ridgeview Senior Living
1009 10th Avenue Northeast
Sauk Rapids, MN 56379

RE: Project Number(s) SL20619016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 23, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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.

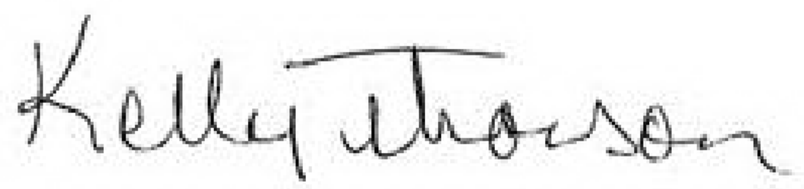
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20619	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW SENIOR LIVING	1009 10TH AVENUE NE SAUK RAPIDS, MN 56379

(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: SL#20619016 On April 21, 2025, through April 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 41 residents; 39 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 1 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a facility TB risk assessment, a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of three employees (licensed practical nurse (LPN)-D), a completed health history and symptom screening for two of three employees (LPN-D and unlicensed personnel (ULP)-E), and initial TB training for one of three employees (LPN)-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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 660		

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0 660	Continued From page 2 the residents). The findings include: During the entrance conference on April 21, 2025, at 10:18 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. The facility TB risk assessment was completed November 19, 2024, and indicated the facility was at a low risk for TB transmission. LPN-D LPN-D had a hire date of December 19, 2021, at a sister facility. LPN-D transferred to this facility and had a hire date of January 6, 2025, to provide supervision and oversight to unlicensed personnel and provide direct services to residents. LPN-D's employee record lacked TB training upon hire, TB history and symptom screen and a two-step TST or other evidence of TB screening such as a blood test. ULP-E ULP-E had a hire date of February 21, 2023, and provided direct care services to licensee residents. ULP-E's record lacked a TB history and symptom screen. On April 22, 2025, at 10:23 a.m. licensed assisted living director (LALD)-A stated LPN-D's employee record was missing the TB symptom screen and	0 660		

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0 660	Continued From page 3 TB testing. She stated some of LPN-D's employee records had not been transferred from their sister facility. On April 22, 2025, at 11:02 a.m., LALD-A stated the sister facility staff updated her they were unable to locate records of a TB symptom screen or any TB testing for LPN-D. LALD-A stated they were aware of the TB requirements and confirmed that the training, screening and testing documents were missing from the employee record. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include an annual facility TB risk assessment. The guidelines also indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's TB Infection Control Plan dated March 5, 2025, indicated [the facility] will have an infection control program in place to ensure that all residents, employees, volunteers, and guests are free from infectious tuberculosis. Tuberculosis screenings are required for all employees who share the same air space as the resident/tenant, both paid and unpaid, at the time of hire or more often as indicated. An employee may only begin direct care after a negative TB symptom screen and a negative IGRA or 1st step	0 660		

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0 660	Continued From page 4 TST. A negative test administered within 90 days of hire is acceptable. The 2nd-step TST may be done after the healthcare worker (HCW) begins working. All reports of TST or IGRA results as well as any related chest x-ray results are to be maintained in the employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On April 21, 2025, at 11:15 a.m., the surveyor	0 775		

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0 775	Continued From page 5 toured the facility with licensed assisted living director (LALD)-A. During the facility tour, the surveyor observed the following: ASSISTED LIVING BUILDING CARBON MONOXIDE ALARMS Carbon monoxide alarms were not installed outside and within ten feet of all resident sleeping rooms. During the facility tour interview, LALD-A verified carbon monoxide alarms were not installed inside the resident apartments. Carbon monoxide alarms were installed in several locations throughout the building. In an email received on April 23, 2025, from maintenance director (MD)-G, it was verified the existing carbon monoxide alarms were not tied into the building fire alarm system. When carbon monoxide alarms are not tied into the building fire alarm system, carbon monoxide alarms are required to be installed within ten feet of all sleeping rooms. Carbon monoxide alarm and detection systems in existing buildings are required to be installed in accordance with MSFC in Minnesota Rules Chapter 7511. DEMENTIA CARE BUILDING OBSTRUCTED EGRESS Illuminated exit signs were installed above both doors leading out into the exterior courtyard for the dementia care building. The courtyard was enclosed by a fence, and a lock requiring a key to unlock was installed on the fence gate. A coded key box was also installed on the fence gate. During the facility tour interview, LALD-A stated the key for the gate lock was kept inside the coded key box. When locks are installed on fence gates as part of the egress path leading to the public way from marked exit doors, the locking system is required to comply with MSFC in Minnesota Rules Chapter 7511.	0 775		

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0 775	Continued From page 6 TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
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) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 7 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide 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 21, 2025, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP at least twice per year, evident by a lack of documentation to support the training had been completed. Records for employee FSEP training completed between March 2024 and April 2025 were requested by the surveyor. During an interview on April 21, 2025, at 3:30 p.m., LALD-A verified these employee FSEP training records were not available. Record review indicated the licensee failed to	0 810		

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0 810	Continued From page 8 provide fire safety and evacuation training to residents at least once per year, evident by the lack of documentation to support the training had been completed. Records for resident training completed between March 2024 and April 2025 were requested by the surveyor. During an interview on April 21, 2025, at 3:30 p.m., LALD-A verified these resident training records were not available. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by fire drill logs lacking the required frequency. Two fire drills were recorded in 2025, completed in February and March. Four fire drills were recorded in 2024, completed in April, May, June, and November. During an interview on April 21, 2025, at 3:30 p.m., LALD-A verified the evacuation drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff	01440		

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01440	Continued From page 9 performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of one employee (unlicensed personnel (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 the residents). The findings include: During the entrance conference on April 21, 2025, at 10:18 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements.	01440		

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01440	Continued From page 10 Unlicensed personnel (ULP)-E had a hire date of February 21, 2023, and provided direct care services to residents. ULP-E's employee record lacked documentation of direct supervision of performing a delegated task within 30 days of providing services to verify the work was performed competently and to identify problems and solutions to address issues relating to the staff's ability to provide the services. On April 22, 2025, at 2:27 p.m., LALD-A stated, "we know what we walked in to, and we were expecting some things to be missing". CNS-B stated she was aware of the supervision requirement and had been attempting to update employee's files. The licensee's Delegation and Supervision of Unlicensed Personnel policy dated June 1, 2023, indicated ULP's must be supervised by an RN within 30 days after the individual begins working for the assisted living and thereafter as needed based on performance. This requirement also applies to staff that have not performed delegated tasks for one year or longer. Documentation of supervision activities must be retained in employee personnel records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following	01470		

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01470	Continued From page 11 topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member 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	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20619	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW SENIOR LIVING	1009 10TH AVENUE NE SAUK RAPIDS, MN 56379

(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
01470	Continued From page 12 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living facility licensing requirements and regulations included all required content for two of three employees (licensed practical nurse (LPN)-D and unlicensed personnel (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 the residents). The findings include: LPN-D LPN-D began employment on January 6, 2025, to	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20619	A. BUILDING: _____ B. WING _____	04/23/2025

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RIDGEVIEW SENIOR LIVING	1009 10TH AVENUE NE SAUK RAPIDS, MN 56379

(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
01470	Continued From page 13 provide oversight to unlicensed personnel and to provide direct services to residents. LPN-D's employee record lacked the following required orientation content: - overview of assisted living statutes - reporting maltreatment of vulnerable adults or minors - handing of resident complaints, reporting of complaints, where to report - consumer advocacy services - review of types of assisted living services the employee will provide and provider's scope of license ULP-E ULP-E began employment on February 21, 2023, to provide direct care services. ULP-E's employee record lacked the following required orientation content: - overview of assisted living statutes - handing of resident complaints, reporting of complaints, where to report - consumer advocacy services - review of types of assisted living services the employee will provide and provider's scope of license On April 22, 2025, at 2:27 p.m., LALD-A stated, "We know what we walked in to, and we were expecting some things to be missing." She stated Relias (training program) courses are assigned by corporate staff and not all staff were assigned the required courses. LALD-A confirmed that LPN-D was missing required orientation following her transfer from another facility and stated, "we dropped the ball". The licensee's Orientation for Assisted Living	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20619	A. BUILDING: _____ B. WING _____	04/23/2025

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RIDGEVIEW SENIOR LIVING	1009 10TH AVENUE NE SAUK RAPIDS, MN 56379

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01470	Continued From page 14 Staff policy dated August 1, 2021, indicated all staff of assisted living providing and supervising direct care services must complete an orientation to assisted living licensing requirements and regulations before providing direct care services to clients. All staff must be trained and competent in the provision of assisted living services consistent with current practice standards and appropriate to resident needs. The assisted living facility shall retain evidence in the employee records of the staff who have satisfied the orientation and training requirements of this section. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to	01530		

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01530	Continued From page 15 dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure employees received eight hours of initial dementia care training within the first 80 hours worked for one of one employee (licensed practical nurse (LPN)-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 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: LPN-D began employment on January 6, 2025, to provide oversight to unlicensed personnel and to provide direct services to residents. LPN-D's orientation and training record lacked documentation of the required number of hours of dementia care training. The training record dated April 22, 2025, included: -care of residents with dementia .75 (hours) -communicating effectively .25 -dementia care: ethical considerations .5 -behavioral health for older adults 1	01530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20619	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW SENIOR LIVING	1009 10TH AVENUE NE SAUK RAPIDS, MN 56379

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01530	Continued From page 16 -handling aggressive behaviors .5 -dementia care: understanding Alzheimer's disease .5 On April 22, 2025, at 2:27 p.m., LALD-A confirmed that LPN-D was missing required dementia orientation following her transfer from a another facility and stated, "we dropped the ball". The licensee's Orientation for Assisted Living Staff policy dated August 1, 2021, indicated 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. The assisted living facility shall retain evidence in the employee records of the staff who have satisfied the orientation and training requirements of this section. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to keep a medication in	01890		

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	20619	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEVIEW SENIOR LIVING	1009 10TH AVENUE NE SAUK RAPIDS, MN 56379

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01890	Continued From page 17 its original container bearing the original prescription label. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 21, 2025, at 2:17 p.m., the surveyor, along with unlicensed personnel (ULP)-F observed the medication cabinets. The surveyor found one bottle of lidocaine 2% solution lacked a prescription label. On April 21, 2025, at 2:31 p.m. ULP-F stated the lidocaine 2% solution belonged to R5. She stated that R5 is the only resident that received that medication, so all staff know who it belonged to. ULP-F stated the medication is normally in a box with a pharmacy label on it and she was unsure why the box was discarded, as it should be kept in the medication cart. On February 21, 2025, at 3:19 p.m., clinical nurse supervisor (CNS)-B stated the staff were trained to keep the medication in the original package with the prescription label. The licensee's Medication Storage in the Facility policy dated November 2018, indicated all medications dispensed by the pharmacy are stored in the container with the pharmacy label.	01890		

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01890	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: seven (7) days	01890		
02040 SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors. This deficient practice had the ability to affect more than a limited number of residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02040	Continued From page 19 pervasive). Findings include: On April 21, 2025, a safety risk assessment or hazard vulnerability assessment for the physical environment was requested by the surveyor. A hazard vulnerability assessment was provided by licensed assisted living director (LALD)-A. The assessment had been completed for emergency preparedness and was not specific for the physical envionrment. Additionally, the assessment did not include mitigation of identified hazards to protect dementia care residents from harm. During an interview on April 21, 2025, at 3:30 p.m., LALD-A verified a safety risk assessment or hazard vulnerability assessment with mitigation factors for the physical environment on and around the property was not available. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164
651-201-4500

Type: Full
Date: *04/21/25*
Time: 11:30:20
Report: 1037251110

Food and Beverage Establishment Inspection Report

Location:

Ridgeview Senior Living
1009 10th Avenue Ne
Sauk Rapids, MN56379
Benton County, 05

Establishment Info:

ID #: 0038946
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202515228
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

Hot Water: = at 164 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER MEMORY CARE
Violation Issued: No

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Quaternary Ammonia: = 400 at Degrees Fahrenheit
Location: SPRAY BOTTLE MEMORY CARE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 198 Degrees Fahrenheit - Location: SHREDDED TURKEY
Violation Issued: No

Process/Item: Cooking
Temperature: 200 Degrees Fahrenheit - Location: CORN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: DICED TOMATO
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: SLICED CHEESE
Violation Issued: No

Process/Item: Upright Cooler MEMORY CARE
Temperature: 41 Degrees Fahrenheit - Location: COLESLAW
Violation Issued: No

Process/Item: Hot Holding MEMORY CARE
Temperature: 195 Degrees Fahrenheit - Location: SHREDDED TURKEY
Violation Issued: No

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

DISCUSSED BARE HAND CONTACT, EMPLOYEE ILLNESS RECORDING, COOLING, REHEATING, AND MENU. ONLY PASTEURIZED EGGS ARE USED.

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 1037251110 of 04/21/25.

Certified Food Protection Manager IONE GUSTAFSON

Certification Number: 16275 Expires: 10/07/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037251110

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
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 04/21/25
Time In 11:30:20
Time Out

Ridgeview Senior Living	Address: 1009 10th Avenue Ne	City/State: Sauk Rapids, MN	Zip Code: 56379	Telephone: 3202515228
License/Permit #: 0038946	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

			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:** 04/21/25

Inspector (Signature)