October 6, 2023

Licensee
Meadow Ridge Senior Living
7475 Country Club Drive
Golden Valley, MN 55427

RE: Project Number(s) SL31962015

Dear Licensee:

On October 5, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 2, 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: 1-866-890-9290

HHH

Electronically Delivered

September 6, 2023

Licensee
Meadow Ridge Senior Living
7475 Country Club Drive
Golden Valley, MN 55427

RE: Project Number(s) SL31962015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 2, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
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 $3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

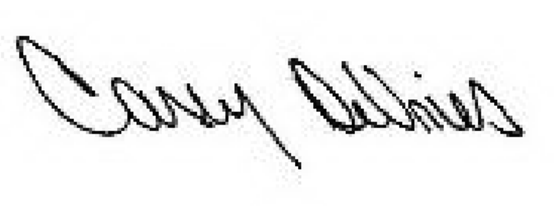
REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 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,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31962	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW RIDGE SENIOR LIVING	7475 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

(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: SL31962015-0 On July 31, 2023, through August 2, 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 88 active residents; all of whom were receiving services under the Assisted Living with Dementia Care license. An immediate correction order was identified on August 1, 2023, issued for SL31962015-0, tag identification 2310. On August 2, 2023, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, widespread scope violation.	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 License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 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 according to the Minnesota Food Code. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated July 31, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be	0 510		

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0 510	Continued From page 2 consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control related to gloving and hand hygiene for three of three unlicensed personnel ((ULP)-D, ULP-F, ULP-E). This had the potential to affect all of the licensee's 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 the potential to affect a large portion or all the residents). The findings include: ULP-D ULP-D was hired March 3, 2023, to provide direct cares and medications to residents. On August 1, 2023, at 7:15 a.m., the surveyor introduced self to ULP-D and explained the survey and observation process. Surveyor	0 510		

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0 510	Continued From page 3 interviewed ULP-D regarding training provided by Licensee. ULP-D stated that training, including medication administration, and infection control procedures, was completed at a corporate office followed by six days of on the floor training and was signed off by a registered nurse (RN) within 30 days. On August 1, 2023, during continuous observation from 7:18 a.m. to 8:20 a.m., the surveyor observed ULP-D perform morning activities of daily living (ADLs) and medication administration on multiple residents. On August 1, 2023, at 7:18 a.m., surveyor observed ULP-D complete medication preparation at the medication cart for R11. Surveyor observed ULP-D wearing a pair of gloves that were put on prior to the surveyor's arrival. Surveyor observed ULP-D removing pills from medication card by popping medications into gloved hand and then transferring the medications from gloved hand to medication cup. After completing medication preparation, ULP-D then entered R11's room for administration of morning medications. Without removing gloves or completing hand hygiene, ULP-D exited R11's room and entered R10's room to drop off breakfast. On August 1, 2023, at 7:26 a.m., ULP-D returned to the medication cart to begin medication preparation for R10. Without completing hand hygiene or changing gloves, ULP-D began removing pills from medication card by popping medications into gloved hand and then transferring the medications from gloved hand to medication cup. ULP-D then entered R10's room and administered medications. After administering medications, ULP-D returned to the	0 510		

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0 510	Continued From page 4 medication cart and removed gloves. Without completing hand hygiene, ULP-D put on clean gloves. On August 1, 2023, at 7:32 a.m., ULP-D began medication preparation for R12. ULP-D began removing pills from medication card by popping medications into gloved hand and then transferring the medications from gloved hand to medication cup. ULP-D then entered R12's room and administered medications. Without removing gloves or completing hand hygiene, ULP-D exited R12's room and returned to the medication cart. On August 1, 2023, at 7:38 a.m., without completing hand hygiene or changing gloves, ULP-D began preparing medications for R13. ULP-D began removing pills from medication card by popping medications into gloved hand and then transferring the medications from gloved hand to medication cup. ULP-D then entered R13's room and administered medications. Without removing gloves or completing hand hygiene, ULP-D exited R13's room and went to dining area to prepare breakfast for a R5. R5's breakfast consisted of toast, which was prepared using the same gloves, and ULP-D placed into a plastic to-go container. On August 1, 2023, at 7:48 a.m., ULP-D returned to the medication cart with R5's breakfast. Without completing hand hygiene or changing gloves, ULP-D began preparing medications for R5. ULP-D began removing pills from medication card by popping medications into gloved hand and then transferring the medications from gloved hand to medication cup. ULP-D then entered R5's room and without completing hand hygiene or changing gloves, administered medications, obtained a blood glucose reading, and	0 510		

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0 510	Continued From page 5 administered insulin. ULP-D then applied a prescribed cream bilaterally to R5's forearms, and administered eye drops. ULP-D then removed gloves and exited room without completing hand hygiene. On August 1, 2023, at 8:20 a.m., ULP-D stated that they had been trained to complete hand hygiene between all cares and glove changes. ULP-F ULP-F was hired December 1, 2022, to provide direct cares and medications to residents. On August 1, 2023, at 7:00 a.m., the surveyor observed ULP-F prepare to administer medications to R14. ULP-F did not wash hands or put on gloves before starting to handle the medications. When ULP-F picked up the medication cup, it flipped and dropped the pills on the medication cart. With bare hands ULP-F picked up the pills, put them back in the cup, and offered them to the resident to take. On August 1, 2023, at 8:40 a.m., ULP-F stated they were trained on infection control procedures. ULP-E ULP-E was hired May 23, 2023, to provide direct cares and medications to residents. On August 1, 2023, at 7:53 a.m., the surveyor observed ULP-E put on gloves to assist R15 to change an incontinence brief in the bathroom. While wearing the same gloves, ULP-E pushed R15 in a wheelchair to the dining room before taking off the gloves and washing hands.	0 510		

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0 510	Continued From page 6 On August 1, 2023, at 8:35 a.m., the surveyor observed ULP-E walk into the first-floor secured unit dining room with gloves on and carrying a soiled brief in a transparent trash bag. ULP-E discarded the trash bag in the dining room trash bin, then ULP-E took off gloves and washed hands. On August 1, 2023, at 8:40 a.m., ULP-E stated they were trained on infection control procedures. ULP-E further stated she was new to the secured unit and had observed other staff in the secured unit discard soiled briefs in the dining room trash bin. On August 2, 2023, at 11:20 a.m., clinical nurse supervisor (CNS)-B stated all employees are trained on infection control procedures. CNS-B further stated employees are supposed to keep all trash in resident rooms after cares and collect it after residents are finished in the dining room. Licensee's Infection Control policy dated February 11, 2022, indicated infection control practices are important to [licensee] for the health and safety of both staff, residents, and guests. The facility has a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases. Licensee's Hand washing policy dated August 1, 2021, indicated: Hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: o Before and after direct contact with a resident; o If moving from a contaminated-body site to a	0 510		

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0 510	Continued From page 7 clean-body site during resident care; o After contact with environmental surfaces or equipment in the immediate vicinity of the resident; o After removing gloves or gowns; o Before, during, and after preparing food; o Before and after eating food; o Before and after caring for someone who is sick; o Before and after treating a cut or wound; o After using the toilet; o After blowing your nose, coughing, or sneezing; o After touching an animal or animal waste; o After handling pet food or pet treats; and o After touching garbage. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;	0 730		

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0 730	Continued From page 8 (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 730		

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0 730	Continued From page 9 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the licensee on July 21, 2021, and discharged to another facility on April 17, 2023. R1's record lacked a discharge summary that complied with part 4659.0120, subpart 9 to include: - diagnoses; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. On August 2, 2023, at 11:31 a.m., registered nurse (RN)-C stated, "I don't do a lot of the discharges or the forms, but we keep them pretty simple. I don't know why that information is not on there I know we recently just redid the forms and we do send that information, I think. All of the DC [discharge] summaries look like that, they are all the same. All of our DC resident files are stored upstairs in our file room so I can't show a newer one to you, but like I said the new forms I would think have that information [clinical nurse supervisor (CNS)-O] takes care of all of that."	0 730		

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0 730	Continued From page 10 The licensee is Resident Record - Information and Content policy dated January 6, 2022, indicated the licensee will maintain appropriate and accurate records for each resident that received assisted living services. Resident records must include a discharge summary, including service termination notice and related documentation, when applicable other documentation required under this chapter and relevant to the residence services or status. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and	0 780		

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0 780	Continued From page 11 (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: On a facility tour with the Maintenance Director (MD)-P and Vice President of Operations (VPO)-Q on August 1, 2023, between approximately 3:00 p.m. and 4:30 p.m., it was observed that the sleeping rooms #123 and #311 were equipped with smoke alarms but were not interconnected with the other smoke alarms in the dwelling unit so that actuation of one alarm would cause all alarms to operate. This deficient condition was verified upon testing the alarm system by the MD-P on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		

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01620 SS=F	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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed every 90-days thereafter for four of four residents (R2, R3, R4, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01620		

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01620	Continued From page 13 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents) The findings include: R2 R2's signed service plan completed and signed while the survey was in process on July 31, 2023, indicated R2 received assistance with AM cares, PM cares, activities, bathing, housekeeping, medication administration, escorts, blood glucose monitoring, behavior management, nail care, hearing aid assist, vital signs, laundry, linen change, wellness safety checks, and toileting. R2's record included 90-day nursing assessments dated February 28, 2023, and June 1, 2023. The assessment completed on June 1, 2023, indicated 93 days had passed between assessments. R3 R3's signed Service Plan dated March 2, 2023, indicated R3 received bed rail safety checks, bathing, incontinence care, blood glucose monitoring, dressing, grooming, housekeeping, escorts, laundry, linen changes, wound monitoring, wound care, and medication administration. R3's record included 90-day nursing assessments dated March 24, 2023, and June 24, 2023. The assessment completed on June 24, 2023, indicated 92 days had passed between assessments. R4	01620		

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01620	Continued From page 14 R4's Service Plan dated February 22, 2023, indicated R4 received the following services: medication management, catheter cares, monitoring and reassessment within 14 days of admission and atleast every 90 days and more frequently with resident condition changes. R4's record included 90-day nursing assessments dated March 27, 2023, and July 7, 2023. The assessment completed on July 7, 2023, indicated 102 days had passed between assessments. R6 R6's Service Plan dated July 19, 2023, indicated R6 received the following services: medication management, monitoring and reassessment within 14 days of admission and atleast every 90 days and more frequently with resident condition changes. R6's record included 90-day nursing assessments dated March 25, 2023, and July 11, 2023. The assessment completed on July11, 2023, indicated 108 days had passed between assessments. On July 31, 2023, at 10:20 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated the licensee's expectation was that nursing complete on-going resident assessments at least every 90 days or with change of condition. On August 2, 2023, at 11:34 a.m., registered nurse (RN)-C stated, "assessments should be completed every 90 days and we set the computer to remind us at 84 days. [R2's] assessment is from 5/23/23, so it was started on time, but if I scroll thru, I don't think you can see	01620		

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01620	Continued From page 15 what was completed item by item on what dates- I know there was a few that I forgot to close and lock so I had to go back and recheck them, so they sign on the day they lock. I know you can only go off the day the assessment is locked and signed and they [licensee] have talked to me about that." The licensee's Assessment, Reviews & Monitoring policy dated August 1, 2021, read "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." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was administered as prescribed and in compliance with the resident's medication management plan for one of nine residents (R5) who received medication management. 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: R5 R5 was admitted on August 12, 2021. R5's signed service plan dated August 4, 2022, indicated R5 received services including assistance with medication administration. On August 1, 2023, at 8:05 a.m., the surveyor observed unlicensed personnel (ULP)-D clean the right middle finger of R5 using an alcohol swab and obtain a blood glucose reading. R5's blood glucose reading was 184mg/dl. After recording the blood glucose reading, the surveyor observed ULP-D retrieve R5's Novolog FlexPen. ULP-D dialed the Novolog FlexPen up to 2 units and pressed the push-button of the pen. After pressing the push-button, ULP-D then cleaned the rubber stopper of the pen using an alcohol swab, attached the needle and proceeded to dial	01760		

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01760	Continued From page 17 up the prescribed 13 units of insulin. Without properly priming the needle, ULP-D then cleaned the injection site on R5's upper left region of his abdomen with an alcohol swab and injected the prescribed 13 units of insulin. On August 1, 2023, at 8:20 a.m., ULP-D stated that they were trained to prime insulin pens by dialing 2 units, depressing the button, and then attaching the needle to the pen. R5's medication administration record (MAR) provided the following instructions on insulin administration: 1. Roll the pen gently before use. 2. Remove the pen cap and clean with alcohol wipe. 3. Connect the needle to the pen. 4. Prime the pen with 2 units of insulin. 5. Dial the dose of insulin to be given on the pen. 6. Verify dose with another caregiver, if possible. 7. Clean the injection site with alcohol wipe or soap and water. If using the abdomen, remain 4 inches away from the navel (belly button). 8. Remove the safety cap on the needle. 9. Pinch the skin and inject the needle into the subcutaneous skin, waiting 8-10 seconds before removing from the injection site. 10. Remove the needle from the pen, avoid recapping, and place immediately in sharps container. 11. Replace the cap on the pen and store pen in designated area. 12. Wash hands. 13. Document. The licensee's Insulin policy revised August 1, 2022, indicated that insulin medications must be administered according to the providers orders. The licensee's Insulin policy did not include a	01760		

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01760	Continued From page 18 procedure for priming of insulin pens. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
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 prescription medications were securely locked in a substantially constructed compartment and permitted only authorized personnel to have access. This had the potential to affect all residents of the second-floor secured unit and one of four residents (R15) in the secured unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: Second-floor Secured Unit	01880		

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01880	Continued From page 19 On August 1, 2023, from 7:47 a.m. through 8:20 a.m., the surveyor observed two medication carts that contained all medications for the second-floor secured unit residents receiving medication administration services. The carts were located in the common dining area. One of two carts was observed to be unlocked and unattended, with push lock unsecured. Unlicensed personnel (ULP) were away from the carts, tending to other tasks around the unit, and there were three residents in the common dining area. On August 1, 2023, at 8:21 a.m., unlicensed personnel (ULP)-H stated, "oh I thought she (pointing to a new trainee) locked it. It is expected that it gets locked whenever you walk away, I think I was so nervous I forgot to lock it." On August 2, 2023, at 11:45 a.m., registered nurse (RN)-C stated, "whenever they [ULPs] step away from the med cart they should lock the cart, they [medication carts] should only be unlocked when they [ULPs] are getting medication." First-Floor Secured Unit On August 1, 2023, at 7:53 a.m., during observation of cares, the surveyor observed the following medications in R15's bathroom: - Destin Daily Defense; - Aquation Anti Chafe cream; - Moisture Barrier cream; - Diaper Rash Ointment; - Debrox Earwax Remover; - Tena Barrier Cream; and - Nexcare Tegaderm pad. On August 2, 2023, at 8:45 a.m., RN-C stated all resident medications and creams are supposed to be kept and locked away from access to	01880		

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01880	Continued From page 20 unauthorized personnel. RN-C also stated family brings some of the creams without informing licensee RN. The licensee Medication Storage policy dated August 1, 2021, read "When medications are managed and stored by Meadow Ridge Senior Living, medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	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 ensure all medications were properly labeled and failed to discard expired medications. 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	01890		

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01890	Continued From page 21 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 August 1, 2023, 8:28 a.m., the surveyor observed the first-floor secured unit medication carts and observed the following unlabeled and/or expired medications: UNLABELED - terbinafine hydrochloride cream 1%; - loki lather norseman disitillery; - two tubes of moisture barrier cream; On August 1, 2023, at 8:49 a.m., the surveyor observed eight insulin pens, all with labels removed that contained various unknown amounts of insulin in the locked medication refrigerator. The licensed practical nurse (LPN)-K stated the insulin pens were put in the door waiting to be destroyed, and staff would not use them because they had no labels. EXPIRED - R14's meclizine tablets 12.5 milligram (mg) one tablet by mouth as needed expired June 2022; - R14's senna tablets 8.6 mg one tablet by mouth as needed expired April 2023; - R6's acetaminophen tablets 325 mg take 2 tablets by mouth as needed expired January 2023; unlabeled and expired - dimethicone skin protectant expired June 2022; and - Covid-19 ag reagent expired February 2, 2023. On August 1, 2023, at 10:08 a.m., the surveyor	01890		

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01890	Continued From page 22 observed the second-floor medication cart and observed the following expired medication: - R16's Dextromethorphan Polistrex Extended Release give 5ml by mouth every 12 hours expired January 10, 2022. On August 2, 2023, at 11:58 a.m., the surveyor observed the second-floor LPN office that was filled with multiple containers which were located on the desk, the counter tops, the filing cabinets, and the table, as well as stacked up and lining three of four walls. Each container had several unidentified medications, along with multiple unlabeled pharmacy set up punch packs, and over the counter medication bottles. LPN-K stated, "Ideally, we try to get rid of meds within a week or so but right now our med safe is full, so a new one has been ordered. We went through and dc'd [discontinued] a bunch of meds like a month or two ago and we haven't been able to destroy meds since." The licensees Medication Disposal policy dated August 1, 2021, read "the facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services	02310		

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02310	Continued From page 23 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for two of four residents (R3, R5) who utilized consumer and hospital bed rails. 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 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: R3 R3 had diagnoses to include Alzheimer's disease with late onset, type 2 diabetes mellitus with hyperglycemia, atrial flutter, hypertension, and chronic kidney disease stage 3. R3's signed Service Plan dated March 2, 2023, indicated R3 received bed rail safety checks, bathing, incontinence care, blood glucose monitoring, dressing, grooming, housekeeping, escorts, laundry, linen changes, wound monitoring, wound care, and medication administration.	02310	On August 2, 2023, the immediacy of correction order 2310 was removed, however, non-compliance remained at a level 3, widespread scope violation.	

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02310	Continued From page 24 On August 1, 2023, from 7:06 a.m., through 7:46 a.m., during service delivery observation, the surveyor observed R3's bed had one black U-shaped bed rail (consumer bed rail) at the top of the bed on the right side. The bed rail was loosely attached to the bed. R3 stated they used the bed rail for getting in and out of bed. Unlicensed personnel (ULP)-G stated R3 used the bed rail often. R3's record included a Side Rail Assessment Form dated March 24, 2023. RN-C provided surveyor with an addition Side Rail Assessment Form dated August 1, 2023, that was completed during the survey process. R3's record lacked: -Documentation the bed rail had been installed, used, and maintained per manufacturer's guidelines; - Risk vs. benefits discussion - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". R5 R5 had a diagnosis of essential (primary) hypertension. R5's Service Plan signed on August 4, 2022, indicated that they received services for bed rail safety checks, linen changes, ambulation assistance, and toileting assistance. On August 1, 2023, at 8:05 a.m., the surveyor	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31962	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW RIDGE SENIOR LIVING	7475 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 25 observed R5's bed positioned with the right side of the bed pressed up against the wall. The bed had two black rectangular shaped hospital bed rails on both sides of bed. Each bed rail was found positioned on the middle to upper portion of the bed. The bed rail on the left side of the bed was firmly attached to the bed. The bed rail on the right side of the bed was loosely attached to the bed, and could be easily pushed and pulled away from the bed. R5 stated that they utilize bed rails daily and that nursing had recently assessed their bed rails and that they had signed paperwork regarding the use of bed rails. R5's record included an initial Side Rail Assessment Form dated August 12, 2021, which only included information pertaining to the bed rail on the left side of R5's bed. R5's Side Rail Assessment Form dated July 27, 2023, also only included information pertaining to the bed rail on the left side of R5's bed. The assessment lacked acknowledgement or detail about the bed rail on the right side of R5's bed. R5's risk agreement on was signed July 27, 2023. R5's record lacked: - Documented assessment of the right-side bed rail. - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". On August 1, 2023, at 9:53 a.m., registered nurse (RN)-C stated, "[R3] got a new bed rail just two or three months ago and I would have to look when	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31962	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW RIDGE SENIOR LIVING	7475 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 26 she got the new bed rail. March 24, 2023, is when she [R3] got the new bedrail, there is no assessment between March 24, 2023, and the one done today, I don't know why that one was not done. Bedrails are usually assessed every three months when I go around to do assessment." On August 1, 2023, at 9:55 a.m., RN- C stated for R5, the location listed on the assessment indicated what side of the bed rail had been assessed. When asked about the right side of the bed, RN-C stated that during their assessment, the right side of the bed rail was in the lowered position, pressed up against the wall and was not visible. RN-C stated that this bed rail had not been assessed. On August 1, 2023, at 10:04 a.m., surveyor asked how many residents with bed rails would not be up to date with bedrail assessments and RN-C stated, "probably most residents will not be up to date", surveyor asked why the bed rail assessments were not up to date and RN-C stated, "I really don't know why, I do not have an answer for that." On August 1, 2023, at 10:04 a.m., clinical nurse supervisor (CNS)-B stated, "In February of this year the department of health changed the regulations, so what we were doing prior was annually assessing the bed rails, so when that was changed we decide that we would do them every 90 days with the assessment, so we have been starting to do auditing for everybody with bedrails with their 90 day assessments and we are in the process of getting all bed rail assessments completed right now and we should have it completed by 11:00 a.m., today."	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31962	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW RIDGE SENIOR LIVING	7475 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

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02310	Continued From page 27 The licensee's policy titled Side rails, dated 6/27/2023 states, "When side rails are in use, an RN must conduct an initial assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail, and on every subsequent 90-day or change of need assessment. If the side rail is acting as a restraint, appropriate action should be taken. The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated 2000, and revised April 2010, indicated following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31962	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW RIDGE SENIOR LIVING	7475 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427

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02310	Continued From page 28 includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *07/31/23*
Time: 12:00:00
Report: 8041231216

Food and Beverage Establishment Inspection Report

Location:
Meadow Ridge Senior Living
7475 Country Club Drive
Golden Valley, MN55427
Hennepin County, 27

Establishment Info:
ID #: 0038460
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637627300
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

1. TCS FOODS IN THE KITCHEN REACH-IN COOLER ABOVE 41F. TCS FOODS DISCARDED DURING INSPECTION. SEE TEMP. LOG. 2. MILK IN THE CONTINENTAL BREAKFAST COOLER MEASURED 46F. MILK RECENTLY STOCKED AND TEMPERATURE DIAL WAS ADJUSTED DURING INSPECTION.

Comply By: 07/31/23

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

SECOND FLOOR MEMORY CARE KITCHEN DISH MACHINE NOT ACHIEVING A UTENSIL SURFACE TEMPERATURE OF AT LEAST 160F (115F MEASURED). DISCONTINUE USE UNTIL MACHINE IS ADJUST/REPAIRED.

Comply By: 07/31/23

6-300 Physical Facility Numbers and Capacities

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

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

NO PAPER TOWELS AVAILABLE AT THE 1ST FLOOR MEMORY CARE KITCHEN HAND SINK. DISPENSER WAS NOT WORKING.

Comply By: 07/31/23

2-400 Hygenic Practices

2-401.11A

MN Rule 4626.0105A Employees must not eat or use tobacco in food preparation or utensil washing areas.

OBSERVED EMPLOYEE FOOD ON THE FOOD PREP COUNTER IN THE MEMORY CARE KITCHENS. CORRECTED ON SITE.

Comply By: 07/31/23

2-400 Hygenic Practices

2-401.11B

MN Rule 4626.0105B Food employees must use a closed beverage container within the food preparation or utensil washing areas.

EMPLOYEE BEVERAGES WITHOUT LIDS FOUND ON THE SHELF ABOVE THE WAREWASHING SINK AND ON THE COUNTER IN THE MEMORY CARE KITCHEN (1ST FLOOR). CORRECTED ON SITE.

Comply By: 07/31/23

4-300 Equipment Numbers and Capacities

4-303.11A

MN Rule 4626.0721A Provide cleaning agents to clean equipment and utensils during all hours of operation.

NO DETERGENT HOOKED UP TO THE 1ST FLOOR MEMORY KITCHEN DISH MACHINE.

Comply By: 07/31/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

MAIN KITCHEN- THE UPRIGHT COOLER AND THE REACH-IN COOLER ARE NOT HOLDING FOOD AT PROPER TEMPERATURE. NOTE: TCS FOODS NOT STORED IN UPRIGHT COOLER TODAY. ADJUST/REPAIR OR REPLACE UNITS.

Comply By: 07/31/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: 3 comp. sink
Violation Issued: No

Utensil Surface Temp.: = at 165 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Utensil Surface Temp.: = at 160 Degrees Fahrenheit
Location: 1st floor memory care dish machine
Violation Issued: No

Utensil Surface Temp.: = at 115 Degrees Fahrenheit
Location: 2nd floor meory care dish machine
Violation Issued: Yes

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: 2nd floor memory care dispenser
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: 1st foor memory care dispenser
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: Degrees Fahrenheit - Location: upright kool-it cooler: ambient air temp.
Violation Issued: Yes

Process/Item: Hot Holding
Temperature: 189 Degrees Fahrenheit - Location: steam table: broccoli
Violation Issued: No

Process/Item: Hot Holding
Temperature: 172 Degrees Fahrenheit - Location: steam table: alfredo
Violation Issued: No

Process/Item: Hot Holding
Temperature: 174 Degrees Fahrenheit - Location: steam table: pasta
Violation Issued: No

Process/Item: Hot Holding
Temperature: 158 Degrees Fahrenheit - Location: soup well: tomato
Violation Issued: No

Process/Item: Hot Holding
Temperature: 167 Degrees Fahrenheit - Location: steam table: hot dog
Violation Issued: No

Process/Item: Cold Holding
Temperature: 50 Degrees Fahrenheit - Location: kitchen reach-in cooler: cottage cheese
Violation Issued: Yes

Type: Full
Date: *07/31/23*
Time: 12:00:00
Report: 8041231216
Meadow Ridge Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 60 Degrees Fahrenheit - Location: kitchen reach-in cooler: hard boiled egg
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 46 Degrees Fahrenheit - Location: continental breakfast cooler: milk
Violation Issued: Yes

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: walk-in cooler: baked beans
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: walk-in cooler: chicken
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: walk-in cooler: red potato
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: first floor memory care cooler: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: second floor memory care cooler: milk
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	1	4

Inspection was completed Jeremy Schouveller (Regional Culinary Director) and Ivorey Eastey (Culinary Director). Zach Morth was the lead Health
Regulation Division Nurse Evaluator.

This establishment has a commercial kitchen on the main floor and memory care kitchen on the first and second floor.

Discussed the following:
-Employee illness policy and logging requirements
-Reporting foodborne illness complaints to the health dept.
-Handwashing
-Glove-use and bare hand contact
-Proper food storage
-Thermometer use
-Date marking
-Vomit clean-up procedures
-Restrictions concerning serving a highly susceptible population
-Violations on this report

Type: Full
Date: *07/31/23*
Time: 12:00:00
Report: 8041231216
Meadow Ridge Senior Living

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8041231216 of 07/31/23.

Certified Food Protection Manager: Ivorey

Certification Number: fm117204 Expires: 12/17/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Ivorey Eastey
Culinary Director

Signed: Sarah Conboy
Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us