DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

December 14, 2021

Administrator
Founders Ridge
6600 Auto Club Road
Bloomington, MN 55438

RE: Project Number(s) SL28701015-1

Dear Administrator:

On December 10, 2021, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 11, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

Electronically Delivered

October 6, 2021

Administrator
Founders Ridge
6600 Auto Club Road
Bloomington, MN 55438

RE: Project Number(s) SL28701015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 11, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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 Department of Health 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 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. 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 evaluation:

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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 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 Department of Health within 15 calendar days.

A state licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

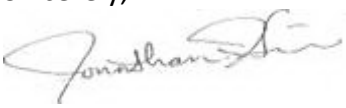
REQUESTING A HEARING

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, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. 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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28701	A. BUILDING: _____ B. WING _____	09/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNDERS RIDGE	6600 AUTO CLUB ROAD BLOOMINGTON, MN 55438

(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 Initial comments ******ATTENTION****** ASSSITED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.10 to 144G.93, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been 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: SL28701015 On, September 8 through September 10, 2021, surveyors of this Department's staff visited the above provider and the following correction orders were issued. At the time of the survey, there were 49 clients receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 Subdivision 1 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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to adhere to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to affect all 49 residents of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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	0 480		

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0 480	Continued From page 2 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 September 8, 2021. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=E	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include statements of the specific measures to be taken to minimize the risk of abuse for three of four residents (R2, R3, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a	0 630		

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0 630	Continued From page 3 client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of clients 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: R2 admitted to facility March 22, 2021, with diagnoses including hypothyroidism (low levels of thyroid hormones), obesity, and depression. R2's record included "Presbyterian Homes Assisted Living Home Care Vulnerability and Safety Review," dated March 24, 2021, indicating, "Resident has some identified areas of potential vulnerability, but there is no signs of abuse or neglect." No specific measures to be taken by licensee to minimize the risk of abuse or neglect identified in the plan. R3 admitted to facility August 4, 2021, with diagnoses including dementia, depression, hypo-osmolality (levels of electrolytes, proteins, and nutrients are lower than normal), and hyponatremia (sodium levels lower than normal). R3's record included unsigned and undated, "Presbyterian Homes Assisted Living Home Care Vulnerability and Safety Review," indicated, "Resident has some identified areas of potential vulnerability, but there is no signs of abuse or neglect." No specific measures to be taken by licensee to minimize the risk of abuse or neglect identified in the plan. R4 admitted to facility March 10, 2021, with diagnoses including dementia, Parkinson's, and Type 2 Diabetes. R4's Vulnerability and Safety Review dated March	0 630		

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0 630	Continued From page 4 11, 2021, indicated, "Resident has some identified areas of potential vulnerability, but there is no signs of abuse or neglect." The record lacked specific measures to be taken by licensee to minimize the risk of abuse or neglect identified in the plan. On September 10, 2021, registered nurse (RN)-C and administrator identified forms labeled, "Presbyterian Homes Assisted Living Home Care Vulnerability and Safety Review," as licensee's individual abuse prevention plan (IAPP) and lacked specific measures to be taken by the licensee to minimize risk of abuse or neglect identified for each resident. RN-C stated form lacked interventions individualized for each resident and form was used for all residents. Licensee's, Vulnerable Adult Abuse Prevention Plan policy dated July, 2021, reads, "This plan will also include the residents susceptibility to abuse be another individual, including other vulnerable adults, the person's risk of abusing other vulnerable adults, and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 780 SS=E	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:	0 780		

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0 780	Continued From page 5 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observations and interview, the facility failed to comply with the State Fire Code in Minnesota Rules, chapter 7511. Per MN Fire Code and NFPA by use of a door wedge or other device to hold open doors in multiple resident rooms and other required doors throughout the facility, fire sprinkler heads not installed as designed and free of obstructions or debris to work property and effectively to protect the facility, and use of unfused and unapproved power strips and multiplug adapters. This had the potential to affect all 49 residents of the facility 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	0 780		

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0 780	Continued From page 6 client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings as reported from engineering surveyors include: Use of a door wedge or other device to hold open doors in multiple resident rooms and other required doors throughout the facility: On September 8, 2021, during a 10:45 a.m. facility tour with the Environmental Services Director (ESD)-F and the Regional Engineering Manager (REM)-G, it was observed that the doors for resident rooms 242, 243, 253, 254, 255, 258, the laundry, and Homecare Office on second floor were all propped open by a wedge or other device. It was also observed that resident room 349 on third floor was propped open by a similar device. During an interview with REM-G, he indicated that staff prop open doors to allow a single staff member to escort the resident out of the room without having to deal with the door closer and closed door. It was observed in each instance that staff did not remove wedge or other device upon leaving the room and that the door was left propped open unattended. Doors that are not allowed to automatically close as designed can compromise fire containment and fail to protect the path of egress in the event of a fire. Obstructed sprinkler heads: On September 8, 2021, during a 10:45 a.m. facility tour with ESD-F and REM-G, it was	0 780		

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0 780	Continued From page 7 observed that the sprinkler head by the exit door on the first floor of the egress stairwell "F" had a red cover over the sprinkler head. This red cover is identical to other covers found in the main sprinkler room that are used to cover and protect the sprinkler head in the event of painting or drywall installation or repair. Further, it was observed that the sprinkler head in the second-floor laundry was covered with laundry lint. ESD-F verified the observations. Any obstruction or debris on a sprinkler head will affect the ability for the heat to trigger the activation during a fire event. Use of unfused and unapproved power strips and multiplug adapters: On September 8, 2021, during a 10:45 a.m. facility tour with ESD-F and REM-G, it was observed that there was an unfused power strip with an altered male plug end to power devices in the closet. Further observation showed that the compromised plug strip was plugged into a second power strip, ultimately "daisy-chaining" the power strips. ESD-F verified the observations. Altered plugs and plug strips void the listing of the device and may compromise any fire and electrical safety features of the device. The use of an unfused and unapproved plug strip can allow the possible overloading of the device and poses a fire risk for the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 8 (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, the facility failed to provide and maintain the building physical environment including walls, floors, ceiling, furnishings, equipment including air handling system in a continuous state of good repair and operation for health, comfort, and well-being of residents in accordance with a maintenance and repair program. This has the potential to affect all 49 residents of the facility and staff. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a 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 as reported from engineering surveyors include: On September 8, 2021, during a 10:45 a.m. facility tour with the Environmental Services Director (ESD)-F and the Regional Engineering Manager (REM)-G, it was observed that there was damaged and missing cove base in the doorway of the first-floor kitchen area. ESD-F verified the observation. This base is required in	0 800		

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0 800	Continued From page 9 the kitchen environment as part of health requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one	0 810		

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0 810	Continued From page 10 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide the required documentation on fire safety and evacuation plans, as well as required evacuation drills. In addition, the facility failed to provide documentation on staff training and training plan frequency related to evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a 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 as reported from engineering surveyors include: The facility failed to develop and maintain fire safety and evacuation plans to include: 1. location and number of residents sleeping rooms. 2. employee actions to be taken in the event of a fire or similar emergency. 3. fire protection procedures necessary for residents; and 4. procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28701	A. BUILDING: _____ B. WING _____	09/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNDERS RIDGE	6600 AUTO CLUB ROAD BLOOMINGTON, MN 55438

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0 810	Continued From page 11 On September 8, 2021, at approximately 10:00 a.m., a review of the facility records was conducted with the Environmental Services Director (ESD)-F regarding fire safety and evacuation plan. Based on this review, records did not show that there was a fire safety and evacuation plan in place that had all requirements based on MN Statute 144G.45 subd.2(b). On September 8, 2021, during a 10:00 a.m. interview, ESD-F was asked to provide further detail on the fire safety and evacuation plan, but he was unable to produce a plan or further detail. The Regional Engineering Manager (REM)-G did arrive on site at the end of the interview and provided a copy of a policy for all the locations that met the requirements, but a plan specific to the facility was not produced. The facility failed to provide an employee training schedule or policy on fire safety and evacuation training after initial hire: On September 8, 2021, at approximately 10:00 a.m., a review of the facility records was conducted with ESD-F regarding fire safety and evacuation plan. Based on this review, records show that employees only received fire safety training at initial hire and were scheduled to receive no further training beyond that point. On September 8, 2021, during a 10:00 a.m. interview, ESD-F was asked to provide further detail on the training requirements, but he was unable to produce a policy detailing this requirement. The Regional Engineering Manager (REM)-G did arrive on site at the end of the interview and provided a copy of a policy for all the locations that met the requirements for	0 810		

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	28701	A. BUILDING: _____ B. WING _____	09/11/2021

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0 810	Continued From page 12 training, but a plan had not been implemented in this specific facility. For residents who are capable of assisting in their own evacuation, the facility failed to provide annual training on the proper actions to take in the event of a fire to include movement, evacuation, or relocation: On September 8, 2021, at approximately 10:00 a.m., a review of the facility records was conducted with ESD-F regarding fire safety and evacuation training. Based on this review, records show that residents who are capable of assisting in their own evacuation are not provided with an option for training to take proper actions in the event of a fire or emergency situation. On September 8, 2021, during a 10:00 a.m. interview, ESD-F indicated that the facility is developing a policy on this but confirmed is no policy or training in place for the residents at this time. A large portion of this facility does have residents capable of assisting in their own evacuation, which can greatly increase evacuation time and efficiency if properly trained. The facility did not conduct evacuation drills for employees twice per year per shift with at least one evacuation drill every other month as prescribed by MN Statute 144G.45(f): On September 8, 2021, at approximately 10:00 a.m., a review of the facility records was conducted with ESD-F regarding fire safety and evacuation training. Based on this review, records show that there is not currently a structured schedule for evacuation drills for employees. On September 8, 2021, during a 10:00 a.m.	0 810		

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0 810	Continued From page 13 interview, ESD-F indicated that the facility does perform drills with staff members, which all members sign off on, but it is not exclusive to evacuation drills and some more involve fire safety. While some of the trainings appear to qualify, it is not to the frequency prescribed by MN Statute 144G.45 subd.2(f). REM-G did arrive on site at the end of the interview and provided a copy of a policy for all the locations that met the requirements for evacuation drills, but the policy had not been implemented in this specific facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided for two of two employees (RN-A, ULP-B) with records reviewed. 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	01480		

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01480	Continued From page 14 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: Registered Nurse (RN)-A and unlicensed personnel (ULP)-B records lacked documentation of orientation to residents receiving care from licensee. On September 9, 2021, observed ULP-B administering medications to R4 per prescriber orders. ULP stated medications are provided three (3) times a day and blood glucose monitoring occurred in the morning prior to the day shift starting. ULP-B stated cares had been provided since R4 moved into the facility. On September 10, 2021, registered nurse (RN)-C and administrator stated during, "huddle," (a time when the nurses review new or changed resident information with staff on that shift), the resident information would be provided to staff working, but no documentation for the review is maintained. RN-C stated this was the practice for entire campus to ensure information is passed to the oncoming shift, but no documentation would be available to review. Licensee's MN AL Staff Orientation to Individual Resident Policy dated August 1, 2021, read, "Current Plan of Care - Upon admission and throughout the changes in condition of a resident, the RN will update the staff verbally, in writing or electronically of the changes in the service/care plan. Updates will be reviewed to the level and scope of the staff's responsibility. This may include written updates to the individualized abuse prevention plan, (IAPP), the medication administration record, the service charting, care	01480		

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01480	Continued From page 15 plan, or assignment sheets." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01480		
01620 SS=D	144G.70 Subd. 2 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	01620		

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01620	Continued From page 16 (RN) conduct ongoing client monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of four clients (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted January 27, 2020, and had diagnoses to include diabetes, heart failure, chronic kidney disease and dementia. R1's record included documentation of a comprehensive nursing assessment completed March 31, 2021. No further assessment was documented in R1's record. During an interview September 9, 2021, at 3:20 p.m. registered nurse (RN)-C verified no further assessments were documented in R1's record. During an interview on September 9, 2021, at 3:33 p.m. RN-C stated the RN assigned to complete the assessment for R1 did not complete the assessment and it was their last day of employment. RN-C further stated a reassessment would be completed immediately for R1. The licensee's MN AL Nursing Assessment Policy, updated August 4, 2021, indicated the RN would complete an ongoing reassessment not to	01620		

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01620	Continued From page 17 exceed 90 days from the previous assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=D	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and the facility to document	01640		

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01640	Continued From page 18 agreement on the services to be provided for one of four residents (R1) with records reviewed. 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: R1 was admitted January 27, 2020, and had diagnoses to include diabetes, heart failure, chronic kidney disease and dementia. R1's service agreement dated January 28, 2021, lacked a signature or other authentication by the resident or by the facility, documenting agreement on the services to be provided. During an interview on September 9, 2021, at 3:20 p.m., registered nurse (RN)-C verified the current service plan did not include a signature by a facility representative or by the client or client representative. The licensee's MN AL Service Plan Policy dated August 1, 2021, indicated, "Service plans and any revisions to service plans will have a signature or other authentication by the facility and by the resident." No further information was provided. TIME PERIOD TO CORRECT- Twenty-one (21) days	01640		

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02040	Continued From page 19	02040		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide a hazard vulnerability assessment for the facility. This had the potential to affect all 49 residents of the facility and staff. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a 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 as reported from engineering surveyors include: The facility failed to perform a hazard vulnerability assessment for safety risks on and around the property. The hazards indicated on the assessment must be assessed and mitigated to	02040		

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02040	Continued From page 20 protect the residents from harm. On September 8, 2021, at approximately 10:00 a.m., a review of the facility records was conducted with the Environmental Services Director (ESD)-F regarding fire safety and evacuation training. Based on this review, records show that a hazard vulnerability assessment for the property had not been conducted or documented. On September 8, 2021, during a 10:00 a.m. interview, ESD-F indicated the facility lacked a hazard vulnerability assessment in place for this facility. The Regional Engineering Manager (REM)-G also confirmed through interview the facility lacked a hazard vulnerability assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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

Type: Full
Date: *09/08/21*
Time: 09:30:00
Report: 1013211238

Food and Beverage Establishment Inspection Report

Location:
Founders Ridge
6600 Auto Club Rd
Bloomington, MN55438
Hennepin County, 27

Establishment Info:
ID #: N000001
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Founders Ridge

Phone #:
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.

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO MN CFPM WAS EMPLOYED AT THE FACILITY. THE OPERATOR SIGNED UP FOR A CFPM COURSE. COMPLY WITH ABOVE RULE.

Comply By: 11/08/21

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

THE SEAL WAS MISSING BETWEEN THE DRAIN BOARD AND THE WALL AT THE KITCHEN DISH MACHINE. A BLACK PLASTIC BAG WAS TAPED OVER THIS AREA OF WALL. COMPLY WITH ABOVE RULE.

Comply By: 09/10/21

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

THE FLOOR DRAIN NEAR THE KITCHEN DISH MACHINE WAS MISSING A COVER. COMPLY WITH ABOVE RULE.

Comply By: 09/10/21

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

GREASE WAS ON THE FLOOR BELOW THE FRYER LOCATED ON THE COOK LINE. CLEAN AND MAINTAIN CLEAN. COMPLY WITH ABOVE RULE.

Comply By: 09/08/21

Surface and Equipment Sanitizers

DDBSA,Lactic Acid: = 700,1875 at Degrees Fahrenheit
Location: Sanitizer - Cook Line
Violation Issued: No

Hot Water: = at 162 Degrees Fahrenheit
Location: Kitchen Dish Machine
Violation Issued: No

Hot Water: = at 173 Degrees Fahrenheit
Location: 1st Floor Memory Care Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Scrambled Eggs
Temperature: 170 Degrees Fahrenheit - Location: Warmer
Violation Issued: No

Process/Item: Yogurt
Temperature: 39 Degrees Fahrenheit - Location: Tall Cooler
Violation Issued: No

Process/Item: Sliced Tomatoes
Temperature: 38 Degrees Fahrenheit - Location: Cold Top Cooler
Violation Issued: No

Process/Item: Hamburger
Temperature: 39 Degrees Fahrenheit - Location: Cold Top Cooler
Violation Issued: No

Process/Item: Chicken
Temperature: 39 Degrees Fahrenheit - Location: Low Reach-in Cooler
Violation Issued: No

Process/Item: Cheese
Temperature: 41 Degrees Fahrenheit - Location: Tall Cooler
Violation Issued: No

Process/Item: Soup
Temperature: 166 Degrees Fahrenheit - Location: Vulcan Steam Unit
Violation Issued: No

Process/Item: Mashed Potatoes
Temperature: 38 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Type: Full
Date: *09/08/21*
Time: 09:30:00
Report: 1013211238
Founders Ridge

Food and Beverage Establishment Inspection Report

Process/Item: Ham
Temperature: 38 Degrees Fahrenheit - Location: Walk-in Cooler
Violation Issued: No

Process/Item: Milk
Temperature: 39 Degrees Fahrenheit - Location: Buffet
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	0	4

Discussed final cook temperatures, employee illness policy, hand washing, cleaning, ware washing, sanitizer use, temperature control, reheating, produce washing, date marking, serving highly susceptible populations, and food handling procedures.

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 1013211238 of 09/08/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Merlin VanGerpen
Nutrition & Culinary Director

Signed: JM
Jerry Malloy
Public Health Sanitarian
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us

Report #: 1013211238

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	1	**Date**	09/08/21
No. of Repeat RF/PHI Categories Out	0	**Time In**	09:30:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
Founders Ridge	6600 Auto Club Rd	Bloomington, MN	55438	

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
N000001	Founders Ridge	Full		H

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	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51	X	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	X	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:** 09/08/21

Inspector (Signature) JM