Electronically Delivered

April 22, 2025

Licensee
Polar Ridge Senior Living
2365 Helen Street North
North Saint Paul, MN 55109

RE: Project Number(s) SL31249016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 27, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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.

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

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

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

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 Department of Health 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.

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

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31249	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLAR RIDGE SENIOR LIVING	2365 HELEN STREET NORTH NORTH SAINT PAUL, MN 55109

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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: SL #31249016-0 On March 24, 2025, through March 27, 2025, 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 104 residents, 59 of whom were receiving services under the provider's 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 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 pursuant to 144G.31 Subd. 1, 2 and 3.	
0 510 SS=E	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.	0 510		

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0 510	Continued From page 1 (b)The facility's infection control program must be 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 infection control program that complies with accepted health care, medical and nursing standards for infection control, including cleaning of reusable point of care medical equipment, for 1 of 2 staff observed (unlicensed personnel (ULP)-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-H was hired August 7, 2023, to provide direct patient care. On March 24, 2025, at 2:30 p.m., ULP-H was observed assisting R3 with a blood pressure check. ULP-H placed a wrist style blood pressure cuff on R3's right wrist. ULP-H was unable to	0 510		

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0 510	Continued From page 2 obtain a reading with the wrist cuff and removed it. ULP-H brought the cuff to the health services office, and without disinfecting the cuff, placed it into a plastic case and put the case in a basket that held additional supplies. ULP-H then retrieved an upper arm blood pressure cuff and brought it back to where R3 was sitting. Without disinfecting the cuff, ULP-H placed the cuff on R3's right bicep, obtained a blood pressure reading, and placed the equipment on a counter next to the sink. ULP-H documented the reading in R3's medical record and brought R3's medications to her. ULP-H then retrieved the blood pressure cuff from the counter and brought it back to the health services office. Without cleaning the equipment, ULP-H placed the cuff back into the basket. On March 24, 2025, at 2:45 p.m., ULP-H stated they had been trained by the registered nurse on infection control. On March 27, 2025, at 11:35 a.m., clinical nurse supervisor (CNS)-D stated the medical equipment in the health services office was shared among the residents in the secured dementia care unit and the assisted living. CNS-D stated staff are expected to clean the equipment with disinfectant wipes between resident use. CNS-D further stated the ULP should have cleaned the equipment, and they may have not done it because they had been working too fast. The Centers for Disease Control and Prevention (CDC) guidance titled CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated April 12, 2024, indicated reusable point of care medical equipment such as blood pressure cuffs and oximeters should be cleaned and reprocessed	0 510		

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0 510	Continued From page 3 (disinfected or sterilized) prior to use on another patient or when soiled. The licensee's Infection Prevention and Control Program policy, dated April 2020, indicated the licensee would comply with guidelines consistent with the most up-to-date CDC publications. The policy further indicated all resident care items would be cleaned, disinfected or sterilized according to the use of them. The licensee's document titled, Education: Clean and Safe Environment, dated July 2021, indicated medical equipment used for more than one resident would be disinfected to prevent the spread of infection. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. 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	0 775		

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0 775	Continued From page 4 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 25, 2025, the surveyor toured the facility with licensed assisted living director (LALD)-B and director of environmental services (DES)-A. The following was observed. There were two different rooms in the parking garage that contained sprinkler risers. There were no labels on the outside of the doors indicating that the sprinkler riser was inside of the room. Fire protection equipment shall be identified in an approved manner. Rooms containing controls for air-conditioning systems, sprinkler risers and valves, or other fire detection, suppression or control elements shall be identified for the use of the fire department. Approved signs required to identify fire protection equipment and equipment location shall be constructed of durable materials, permanently installed and readily visible. The exit doors leading into the stairwells on floors 2, 3, and 4 are equipped with delayed egress locking hardware. There is no label on the door indicating that the door is equipped with delayed egress locking hardware. A sign shall be provided on the door and shall be located above and within 12 inches (305 mm) of the door exit hardware. The sign shall read:	0 775		

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0 775	Continued From page 5 PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS. In exit door from the common hallway to stair 4 on 2nd floor was equipped with delayed egress locking hardware. The delayed egress locking hardware would not operate when tested. An attempt to egress shall initiate an irreversible process that shall allow egress in not more than 15 seconds when a physical effort to exit of not more than 15 pounds (67 N) is applied to the egress side door hardware for not more than one second. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the	01440		

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01440	Continued From page 6 individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of three employees (executive director assistant/unlicensed personnel (EDA/ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: EDA/ULP-C was hired August 18, 2024, to provide direct cares for the licensee's residents. On March 24, 2025, during continuous observations from 2:55 p.m. to 3:20 p.m., EDA/ULP-C was observed assisting R2 with personal cares including transfers, incontinent care, dressing and repositioning. EDA/ULP-C's record lacked documentation the RN conducted direct supervision within 30 days of performing delegated tasks.	01440		

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01440	Continued From page 7 On March 26, 2025, at 2:41 p.m., clinical nurse supervisor (CNS)-D stated the 30-day supervision had not been completed for EDA/ULP-C. CNS-D further stated she thought the supervision may have been missed because EDA/ULP-C was part of the management team. The licensee's Service Plan policy, dated September 2023, indicated supervision of unlicensed personnel would be conducted within 30 days of hire and as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01620 SS=D	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	01620		

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01620	Continued From page 8 of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure the registered nurse (RN) completed ongoing comprehensive reassessments using the uniform assessment tool at an interval not to exceed 90 days for one of three residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: R4's service plan, dated October 8, 2024, indicated R4 received services including assistance with medication administration. On March 25, 2025, at 7:20 a.m., unlicensed personnel (ULP)-E was observed assisting R4 with medication administration and dressing. R4's record included a comprehensive nursing assessment, dated November 12, 2024, and a subsequent assessment completed March 3, 2025 (111 days after the previous assessment).	01620		

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01620	Continued From page 9 On March 26, 2025, at 10:45 a.m., clinical nurse supervisor (CNS)-D stated R4's 90-day comprehensive nursing assessment had been done late. CNS-D further stated she was not sure why it was late, and it "might have been an oversite." The licensee Comprehensive Assessment Schedule, revised August 2022, indicated "ongoing client monitoring and reassessment," would be conducted by the registered nurse at least every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (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 and the Office of Ombudsman for Mental Health and Developmental Disabilities. (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,	01640		

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01640	Continued From page 10 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 observation, interview and record review, the licensee failed to ensure a current written service plan was revised to reflect the current services provided for two of four residents (R2, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's signed service plan, dated September 15, 2024, indicated R2 received services including assistance with medication management, incontinence, transfers, bathing, housekeeping, laundry, and oxygen management. R2's unsigned service plan, printed March 25, 2025, indicated R2 no longer received the following services: oxygen management. On March 24, 2025, at 2:45, during continuous observations from 2:55 p.m. to 3:20 p.m., executive director assistant/unlicensed personnel	01640		

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01640	Continued From page 11 (EDA/ULP)-C was observed assisting R2 with transfers, incontinent care, dressing and repositioning. R7 R7's signed service plan, dated September 17, 2024, indicated R7 received services including assistance with medication management, toileting, bathing, grooming and laundry. R7's unsigned service plan, printed March 26, 2025, indicated R7 received the following additional services: skin care and isolation precautions. On March 25, 2025, at 9:20 a.m., ULP-F was observed assisting R7 with medication administration and isolation precautions. On March 26, 2025, at 3:25 p.m., clinical nurse supervisor (CNS)-D identified R2's September 15, 2024, and R7's September 17, 2024, service plans as their last signed service plans. CNS-D stated revisions had been made to each of the service plans, but the changes were not authenticated by the facility and the resident or resident's representative. CNS-D stated she was not sure why the revised service plan had not been signed. The licensee's Service Plan policy, dated September 2023, indicated any revisions to the service plan must include a signature or authentication by the licensee and the resident or resident representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31249	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLAR RIDGE SENIOR LIVING	2365 HELEN STREET NORTH NORTH SAINT PAUL, MN 55109

(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
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in a substantially constructed compartment for one of five residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a 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: R2's signed service plan, dated September 15, 2024, indicated R2 received services including assistance with medication management. R2's nursing assessment, dated March 20, 2025, indicated R2 was unable to self-administer medications. R2's medication administration record for March 2025, indicated R2 received assistance with the following medications: -Baza protect cream 12% (moisture barrier cream	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31249	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLAR RIDGE SENIOR LIVING	2365 HELEN STREET NORTH NORTH SAINT PAUL, MN 55109

(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
01880	Continued From page 13 with zinc used for incontinence) daily at 10:00 a.m. and 8:00 p.m. -Zeasorb-AF powder 2% (antifungal powder used for skin irritation) daily at 10:00 a.m. and 8:00 p.m. On March 24, 2025, at 2:45 p.m., the surveyor observed executive director assistant/unlicensed personnel (EDA/ULP)-C assisting R2 with cares in bed. The surveyor further observed a wash basin sitting on top of R2's nightstand which contained two tubes of barrier cream with zinc and two containers of antifungal powder. On March 24, 2025, at 4:13 p.m., EDA/ULP-C stated the medications should not have been sitting out in R2's room and should have been locked the cabinet. EDA/ULP-C further stated the medications might have been left out because R2 had received a bath earlier that day. On March 27, 2025, at 11:35 a.m., clinical nurse supervisor (CNS)-D stated all R2's medications should have been kept in the locked cabinet, and she was not sure why they would have been left out. The licensee's 7.11 Medication Storage Policy, dated August 1, 2021, indicated medications would be stored consistent with each resident' medication management plan, kept securely locked and stored per manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31249	A. BUILDING: _____ B. WING _____	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLAR RIDGE SENIOR LIVING	2365 HELEN STREET NORTH NORTH SAINT PAUL, MN 55109

(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
01890	Continued From page 14	01890		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to date time sensitive medication for one of five residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: R4's service plan, dated October 8, 2024, indicated R4 received services including assistance with medication administration. R4's medication administration record (MAR), dated March 2025, indicated R4 received 11 units of Lantus (insulin glargine, a long-acting insulin for diabetes) daily at bedtime. On March 25, 2025, at 7:50 a.m., the surveyor observed R4's medication cabinet with unlicensed personnel (ULP)-E. The cabinet contained a	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31249	A. BUILDING: _____ B. WING _____	03/27/2025

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01890	Continued From page 15 Lantus insulin pen. The pen had a date opened sticker with unreadable smeared ink on it. ULP-E stated the smear looked like it might be someone's initials, but she was unable to read them. On March 27, 2025, at 11:35 a.m., clinical nurse supervisor (CNS)-D stated all insulin pens should be labeled with the date they were opened. CNS-D further stated if the label was unreadable, it should have been reported to the nurse to be replaced. CNS-D stated she did not know why it was not reported. The manufacturer's prescribing information for the use of Lantus, insulin glargine injection, revised June 2023, indicated the medication should be discarded 28 days after first use. The licensee's Medications and Treatments policy, revised March 2021, indicated any medication received from the pharmacy in a manufacturer box, bag, or container, should be kept in the original packaging and should be labeled with the specific date of first use. The policy further indicated insulin pens expired 28 days from the time they were opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64974
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *03/24/25*
Time: 13:59:38
Report: 8058251063

Food and Beverage Establishment Inspection Report

Location:

Polar Ridge Senior Living
2365 Helen Street North
North St Paul, MN55109
Ramsey County, 62

Establishment Info:

ID #: 0038155
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6517704028
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = --- at 167 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 400 PPM at --- Degrees Fahrenheit
Location: DISPENSER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: PEPPERS
Temperature: 39 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Process/Item: EGGS
Temperature: 40 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Process/Item: BEEF
Temperature: 40 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Process/Item: STRAWBERRY
Temperature: 36 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Process/Item: SLOPPY JOE
Temperature: 41 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Type: Full
Date: *03/24/25*
Time: 13:59:38
Report: 8058251063
Polar Ridge Senior Living

Food and Beverage Establishment Inspection Report

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: PREP
Violation Issued: No

Process/Item: CUCUMBER
Temperature: 36 Degrees Fahrenheit - Location: PREP
Violation Issued: No

Process/Item: HOT DOG
Temperature: 39 Degrees Fahrenheit - Location: PREP
Violation Issued: No

Process/Item: LASAGNA
Temperature: 178 Degrees Fahrenheit - Location: HOT HOLDING
Violation Issued: No

Process/Item: CUCUMBER
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTOR TAMMY CARLSON

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 8058251063 of 03/24/25.

Certified Food Protection Manager ELIZABETH ANNE LITZELL

Certification Number: 44939 Expires: 12/04/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
ELIZABETH ANNE LITZELL
PIC

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
aaron.gertz@state.mn.us