Electronically Delivered

May 30, 2025

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

RE: Project Number(s) SL20619016

Dear Licensee:

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

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

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

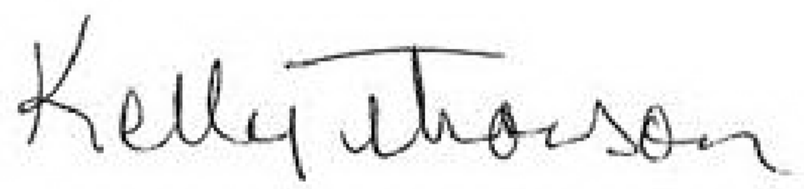
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24077	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERWOOD OF CHANHASSEN	525 LAKE DRIVE CHANHASSEN, MN 55317

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL24077016 On April 21, 2025, through April 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 60 residents; 58 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 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.	
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly	0 650		

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0 650	Continued From page 1 scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records contained the required content for one of two employees (unlicensed personnel (ULP)-F). 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).	0 650		

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0 650	Continued From page 2 The findings include: ULP-F began employment on January 20, 2023. On April 22, 2025, at 8:00 a.m., the surveyor observed ULP-F administer medications. ULP-F's employee record lacked the following: - documentation of a current annual performance review that identified areas of improvement needed and training needs. On April 23, 2025, at 8:55 a.m., licensed assisted living director (LALD)-A stated they could not find an annual performance review for ULP-F and was not sure how it was missed. The licensee's undated Information from Employee Handbook document indicated it is [the facility's] policy to evaluate your performance periodically so that you are kept advised of your contributions and progress. You will be evaluated on the key result areas for your position, as well as: personal vision, personal leadership, personal management, interpersonal leadership, and communication. As a general rule, your review will take place annually on or about the anniversary of your hire date or the date of the most recent position change. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the	0 775		

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0 775	Continued From page 3 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 to keep the facility in compliance with the Minnesota Fire Code. The deficient conditions have 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, 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). Findings include: On facility tour with environmental services director (ESD)-C and regional engineering manager (REM)-D on April 22, 2025, between 9:00 a.m. and 1:00 p.m. the following deficient conditions were observed: FIRE SPRINKLER DEFICIENCIES: The surveyor observed that there were no fire sprinkler heads in (2) storage areas that had been added. Also, there were several noted deficiencies on the 6/20/24 annual report from Viking sprinkler that need to be addressed and one blocked fire sprinkler head in the freezer in the 3rd floor kitchen. FIRE RATED WALL:	0 775		

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0 775	Continued From page 4 The surveyor observed that there was a hole in the rated wall in the 2nd floor furnace room and an access panel in the rated wall behind the dryer in laundry room in dementia care unit. This opening shall be patched to meet the buildings designed wall fire rating and the access cover shall be replaced. LOCK: The surveyor observed that there was a lock on the door handle on the door between the chapel and the library. This door had a lit exit sign above it. The locking hardware shall be removed and the door shall be able to be opened with one motion with no special knowledge or key. CARBON MONOXIDE: The surveyor observed plug in carbon monoxide alarms sporadically placed in the building. These alarms did not meet the fire code. KITCHEN COOKING EQUIPMENT: The surveyor observed that the restraint cables to the moveable gas fired appliance sunder the hood did not have their restraint cables connected to the appliance or the wall. The restraint cables shall be always connected. The deficient conditions were visually verified by ESD-C and REM-D accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7)	0 775		

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0 775	Continued From page 5 days.	0 775		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated to the current health facility identification (HFID) number for two of two employees on the facility provided employee roster (unlicensed personnel (ULP)-I and licensed practical nurse (LPN)-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, 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	01290		

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01290	Continued From page 6 failure that has affected or has potential to affect a large portion or all the residents). The findings include: On April 21, 2025, at 12:00 p.m., the surveyor reviewed the facility's NetStudy 2.0 roster (background study) and compared it to the facility's staff roster and discovered two employees were not affiliated with the licensee's HFID #24077. On April 23, 2025, at 10:25 a.m., campus administrator (CA)-G stated the background studies for those employees were not affiliated because they transferred from a sister facility and there was a gap in human resources at that time and it was missed. CA-G did provide clearance letters from the sister facility. The licensee's undated Background Check policy indicated all applicants for employment are required to disclose all crimes of which they have been convicted, other than minor traffic offenses, and to authorize [the facility] or its agent to conduct a criminal background check. Likewise, any employee who seeks to transfer to or add an alternate job or site within [the facility] for which a background check is required by law will be subject to the required criminal background check. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *04/22/25*
Time: 15:00:00
Report: 8087251098

Food and Beverage Establishment Inspection Report

Location:
Summerwood Of Chanhassen
525 Lake Drive
Chanhassen, MN55317
Carver County, 10

Establishment Info:
ID #: 0038034
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522945500
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

Wash Temperature Gauge: = -- at 167 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temperature Gauge: = -- at 178 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Max Utensil Surface Temp: = -- at 168 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: -1 Degrees Fahrenheit - Location: WALK-IN FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: TUNA SALAD
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: PORK LOIN
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 14 Degrees Fahrenheit - Location: ICE CREAM FREEZER
Violation Issued: No

Process/Item: Cold Holding: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER - SMALL
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER - SMALL
Violation Issued: No

Process/Item: Cold Holding: CUT TOMATO
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER - LARGE
Violation Issued: No

Process/Item: Ambient Air
Temperature: 16 Degrees Fahrenheit - Location: FRY FREEZER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: CUT MELON
Temperature: 38 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 39 Degrees Fahrenheit - Location: STAND-UP COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: 36 Degrees Fahrenheit - Location: DELI BEVERAGE COOLER
Violation Issued: No

Process/Item: Ambient Air
Temperature: -13 Degrees Fahrenheit - Location: DELI ICE CREAM FREEZER
Violation Issued: No

Type: Full
Date: *04/22/25*
Time: 15:00:00
Report: 8087251098
Summerwood Of Chanhassen

Food and Beverage Establishment Inspection Report

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

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH STATE NURSING EVALUATOR WENDY ROBARGE, REGIONAL NUTRITION AND CULINARY DIRECTOR ALLAN GLASS.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING
NOROVIRUS
BARE HAND CONTACT WITH READY TO EAT FOODS
EMPLOYEE ILLNESS
EMPLOYEE EXCLUSION
COOLING METHODS
REHEATING METHODS
SANITIZER CONCENTRATION
DATE MARKING
ALL ITEMS ON THIS REPORT
ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT AND REGIONAL NUTRITION AND CULINARY DIRECTOR ALLAN GLASS.

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 8087251098 of 04/22/25.

Certified Food Protection Manager: JENNA P. DIBBLE

Certification Number: FM105192 Expires: 01/29/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
ALLAN GLASS
REGIONAL DIRECTOR

Signed: _____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us