DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 22, 2023

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

RE: Project Number(s) SL31249015

Dear Licensee:

On February 22, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 20, 2022, evaluation were corrected. This 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,

Jessica Chenze, Supervisor
State Rapid Response Team / State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970 / P.O. Box 3879
St. Paul, MN 55164-0970 / 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-215-6894 / 651-281-9796

HHH

Electronically Delivered

January 18, 2023

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

RE: Project Number(s) SL31249015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 20, 2022, 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.

LICENSING ORDERS
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 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 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), 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:

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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 by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. 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 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 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 of the correction order receipt date.

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 be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

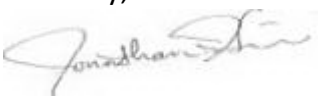
REQUESTING A HEARING

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 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. 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
	31249	A. BUILDING: _____ B. WING _____	12/20/2022

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
0 000	Initial Comments 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: SL31249015-0 On December 12, 2022, through December 20, 2022, 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 68 residents, 66 receiving services under the provider's Assisted Living with Dementia Care license. The immediacy of correction order, tag identification 2310 was removed December 13, 2022, scope and level of noncompliance remained the same.	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 with Dementia Care facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food	0 480		

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0 480	Continued From page 2 and Beverage Establishment Inspection Report, dated December 13, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the	0 730		

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0 730	Continued From page 3 resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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: R6's record lacked a discharge summary to include: - diagnoses; - allergies;	0 730		

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0 730	Continued From page 4 - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status. R6 was admitted to the licensee on February 13, 2021, with diagnoses including: coronary artery disease, severe aortic stenosis, chronic renal failure, bipolar disorder. R6 discharged from the facility on November 30, 2022. R6's record/progress notes did not include information related to discharge. On December 14, 2022, at 2:21 p.m., registered nurse (RN)-B confirmed R6's discharge summary did not include all the required components. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (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:	0 800		

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0 800	Continued From page 5 Based on observation and interview, the licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. 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 resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 20, 2022, approximately 11:00 a.m., survey staff toured the facility with and Licensed Assisted Living Director (LALD)-A and Environment Service Director (ESD)-I. During the facility tour, survey staff observed the following: The trash chute door on the fourth floor did not self-latch. The trash chute door should close and latch completely to maintain the fire resistance integrity of the trash chute system. Second Dining room on the first floor, the radiant heater base board was missing end cap exposing sharp metal edges. During the facility tour interview, LALD-A and ESD-I visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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0 810	Continued From page 6	0 810		
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 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 observation, interview and record	0 810		

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0 810	Continued From page 7 review, the licensee failed to develop a fire safety and evacuation plan with required elements; failed to provide required employee training on fire safety and evacuation; failed to provide training to residents capable of assisting in their own evacuation; and failed to complete required employee evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: An interview and record review were conducted on December 20, 2022, approximately 11:30 a.m. with the Licensed Assisted Living Director (LALD)-A and Environment Service Director (ESD)-I on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the fire safety and evacuation plan did not include the facility specific 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. The facility plan did include some provisions for relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. The policy was a basic policy from a third-party provider and had	0 810		

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0 810	Continued From page 8 not been edited or updated to fit the facility. During interview, (LALD)-A verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training it initial hire. During interview, (LALD)-A stated that the licensee provided annual training to employees, but not twice per year after initial hire on the fire safety and evacuation plan, as required by statute. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. During interview, (LALD)-A stated that the facility did not have documentation or a policy on offering an annual resident training of the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 9-14-22, 6-20-22, 6-3-22, 5-5-22, 5-4-22, 4-7-22, 11-4-21, 11-9-21 with no further drills being documented. And the facility failed to provide two drills on second shift. During interview, (LALD)-A stated that the regional operation manager conducted recorded drills. (LALD)-A verified that there were no further documented drills for the facility and verified this deficient condition.	0 810		

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0 810	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries	01370		

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01370	Continued From page 10 between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for one of three employees (unlicensed personnel (ULP)-D) to include all required content. 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: ULP-D was hired on July 5, 2022, to provide direct care services to residents of the facility. On December 13, 2022, at 8:25 a.m. ULP-D was observed administering medications to R1. ULP-D's employee record lacked documentation of training and competency evaluations for the following topics: - documentation requirements for all services provided; - reports of changes in the resident's condition to the supervisor designated by the facility;	01370		

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01370	Continued From page 11 - basic infection control, including blood-borne pathogens; - maintenance of a clean and safe environment; - appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing; care of teeth, gums, and oral prosthetic devices; care and use of hearing aids; and dressing and and assisting with toileting; - training on the prevention of falls; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - basic nutrition, meal preparation, food safety, and assistance with eating; - preparation of modified diets as ordered by a licensed health professional; - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; - awareness of confidentiality and privacy; - understanding appropriate boundaries between staff and residents and the resident's family - procedures to use in handling various emergency situations; and - awareness of commonly used health technology equipment and assistive devices. On December 13, 2022, at approximately 1:02 p.m., regional operation director (ROD)-H confirmed ULP-D's employee record did not include evidence of the above trainings or competencies. On December 13, 2022, at 1:18 p.m. registered nurse (RN)-B stated ULP-D had been present at an in-person two-day orientation training that she had overseen. RN-B was able to provide evidence ULP-D had attended the training though was unable to provided evidence of	01370		

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01370	Continued From page 12 competencies signed off by a registered nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency was completed for one of three employees (unlicensed personnel (ULP)-D) to include all required content with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01380		

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01380	Continued From page 13	01380		

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:

ULP-D was hired on July 5, 2022, to provide direct care services to residents of the facility.

ULP-D's employee record lacked documentation of training and competency for the following topics:
- observing, reporting, and documenting resident status;
- basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel;
- reading and recording temperature, pulse, and respiration of the resident;
- recognizing physical, emotional, cognitive, and developmental needs of the client;
- safe transfer techniques and ambulation;
- range of motioning and positioning; and
- administering medications or treatments as required.

On December 13, 2022, at approximately 1:02 p.m., regional operation director (ROD)-H confirmed ULP-D's employee record did not include evidence of the above trainings or competencies.

On December 13, 2022, at 1:18 p.m. registered nurse (RN)-B stated ULP-D had been present at an in-person two-day orientation training that she

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01380	Continued From page 14 had overseen. RN-B was able to provide evidence ULP-D had attended the training though was unable to provided evidence of competencies signed off by a registered nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
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 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:	01440		

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01440	Continued From page 15 Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: ULP-D was hired on July 5, 2022, to provide direct care services to residents of the facility. ULP-D's employee record lacked documentation of a registered nurse (RN) supervising ULP-D performing delegated tasks within 30 days of beginning work with the licensee. On December 13, 2022, at approximately 1:02 p.m., regional operations director (ROD)-H confirmed ULP-D's 30-day supervision of delegated tasks had not been completed as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

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01530	Continued From page 16	01530		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-D) received the required amount of dementia care training in the required time frame. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01530		

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01530	Continued From page 17 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: The licensee provided services under an Assisted Living with Dementia Care license. ULP-D was hired on July 5, 2022, to provide direct care services to the licensee's residents. ULP-D's employee record contained evidence the employee received four hours of dementia care training, not the required eight hours of training within 80 working hours of the employment start date. On December 13, 2022, at approximately 1:02 p.m., regional operation director (ROD)-H confirmed ULP-D had not completed the required eight hours of dementia training within 80 hours of the employment start date. The licensee's Memory Care Guide dated June 2022, indicated new hire requirement for dementia care training for licensed practical nurses, home health aides, and other direct care staff was eight hours of training within 80 hours after first day of hire (cannot work with dementia residents until complete). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		

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01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a change of condition assessment for one of one resident (R1) and failed to ensure ongoing reassessment did not to exceed 90 calendar days from the last assessment, for three of five residents (R2, R4, R5). This practice resulted in a level two violation (a	01620		

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01620	Continued From page 19 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 included: R1's Service Addendum dated September 14, 2022, indicated R1 received services including bathing, dressing, grooming, toileting, meal assist set up, and medication administration. R1's assessment dated September 14, 2022, indicated R1 used no physical devices and was able to ambulate safely with or without device. R1's Level of Care Tool dated September 14, 2022, indicated R1 was independent with transfers and needs/receives set up or supervision/reminders with dining/nutrition. R1 also needed assistance with opening food items and cutting food. R1's progress note dated November 15, 2022, at 4:37 p.m., indicated R1 had tested positive for Influenza A. R1's progress note dated November 22, 2022 at 10:07 a.m., indicated, "Resident is up today in wheelchair getting help to eat breakfast. She drank a few sips of water. Got her weight and it's 115# (pounds). In September it was 130#. Updated on the bridge." On December 13, 2022, at 8:13 a.m. unlicensed personnel (ULP)-D and ULP-J were observed getting R1 out of bed for breakfast. Both staff	01620		

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01620	Continued From page 20 assisted R1 with sitting up and transferring into her wheelchair. ULPs then brought R1 into the bathroom and assisted resident with toileting, morning cares, and medication administration before wheeling her out to the dining room. On December 13, 2022, at 8:40 a.m., R1 was observed eating breakfast and drinking fluids independently. R1 ate approximately one third of breakfast then sat quietly and watched the staff and other residents. At 9:01 a.m., activity assistant (AA)-K approached R1 and asked if the resident need any help with breakfast. R1 nodded their head "yes" and (AA)-K then physically assisted R1 with eating the remaining two thirds of the meal. On December 13, 2022, at 2:35 p.m., ULP-L stated R1 "used to walk" about the facility independently, but approximately two weeks ago, was diagnosed with influenza and had experienced increased weakness. ULP-L further stated staff encouraged R1 to use the wheelchair and also were now required to physically assist R1 with eating. On December 13, 2022, at 2:54 p.m. registered nurse (RN)-B confirmed R1 had a change of condition since being diagnosed with influenza and verified the resident required more assistance with transfers, ambulation, and eating. RN-B stated she had not completed a change of condition assessment for R1, and further stated an assessment should have been completed. R2 R2's Service Addendum dated March 15, 2022, indicated R2 received service including bathing, dressing grooming, oral care, medication administration and blood sugar monitoring.	01620		

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01620	Continued From page 21 R2's last two 90-day reassessments dated June 24, 2022, and December 13, 2022, indicated the reassessment exceeded 90-days (172 days later). On December 13, 2022, at 4:17 p.m., RN-B confirmed R2's nursing reassessment had not been completed in the required timeframe. R4 R4's Service Addendum dated August 5, 2022, indicated R4 received services including bathing, dressing, grooming, and toileting assist. R4's last two 90-day reassessments were dated May 26, 2022, and July 5, 2022, with no reassessment since the later (160 days). On December 13, 2022, at 3:00 p.m., RN-B confirmed R4's nursing reassessment had not been completed in the required timeframe. R5 R5's Service Addendum dated August 10, 2022, indicated R5 received services including bathing, toileting, and medication administration. R5's last two 90-day reassessments were dated July 7, 2021, and June 24, 2022, with no reassessment since the later (171 days). On December 13, 2022, at 3:00 p.m., RN-B confirmed R5's ongoing reassessment had not been completed in the required timeframe and stated the facility lacked adequate nursing staff to complete the required reassessments timely. The licensee's Comprehensive Assessment Schedule policy dated August 2022, directed ongoing resident monitoring and reassessment	01620		

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01620	Continued From page 22 be completed at least every 90 days, and with resident change of condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01790 SS=D	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:	01790		

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01790	Continued From page 23 (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) trained and ensured competency for one of three employees (unlicensed personnel (ULP)-D) providing medications for residents with unplanned time away from home when the licensed nurse was not available.	01790		

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01790	Continued From page 24 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 included: ULP-D was hired on July 5, 2022, to provide direct care services to residents of the facility. ULP-D's employee record lacked documentation of competencies for providing medications to residents with medication management who have unplanned time away from home. On December 13, 2022, at approximately 1:02 p.m., regional operation director (ROD)-H confirmed ULP-D's employee record did not include evidence of the above training or competency. On December 13, 2022, at 1:18 p.m. registered nurse (RN)-B stated ULP-D had been present at an in-person two-day orientation training that she had overseen. RN-B was able to provide evidence ULP-D had attended the training though was unable to provided evidence of competency signed off by a registered nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790		

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 _____	12/20/2022

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
01910	Continued From page 25	01910		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's prescription number as applicable, for one of one discharged resident (R6) with record review. 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	01910		

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 _____	12/20/2022

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01910	Continued From page 26 only occasionally). The findings include: The discharge resident roster provided by the licensee, indicated R6 discharged on November 30, 2022, to another facility. R6's service addendum dated August 5, 2022, indicated services included medication administration. R6's Medication Sent Release Form dated November 30, 2022, included medications that had been sent with R6's family member upon discharge. The document identified the medication name, strength, quantity, and signature of the nurse and family member. The document did not include the prescription number for any of the identified medications including: lorazepam (anxiety), diclofenac gel (pain and swelling), lubricating plus (dry eyes), fiber powder (supplement), Bacitracin (topical antibiotic), acetaminophen (pain), amlodipine (blood pressure), aspirin (heart health), atorvastatin (cholesterol), B-complex (supplement), isosorbide (anti-anginal), ferrous sulfate (iron supplement), Losartan (blood pressure), metoprolol (blood pressure), olanzapine (anti-psychotic), pantoprazole (acid reflux), preservision (eye health), tamsulosin (enlarge prostate), vitamin D (supplement), divalproex (mood stabilizer), donepezil (dementia), melatonin (supplement for sleep), senna (constipation), trazodone (antidepressant). On December 14, 2022, at 2:21 p.m. registered nurse (RN)-B confirmed the facility's Medication Sent Release Form used for reconciliation of medications, did not include the prescription	01910		

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 _____	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01910	Continued From page 27 number as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02180 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Access to secured outdoor space and walkways that allow residents to enter and return without staff assistance must be provided. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure behavioral symptoms identified were addressed on the service plan for one of two residents (R2) in memory care. 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).	02180		

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 _____	12/20/2022

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02180	Continued From page 28 The findings include: The licensee had an assisted living with dementia care (ALFDC) license, effective August 1, 2021. R2's diagnoses included, but were not limited to, diabetes and heart disease. R2's 90-day nursing assessment dated December 13, 2022, identified the resident exhibited confusion, impaired decision making, and would yell out and say curse words. On December 13, 2022, at 8:47 a.m. R2 was observed seated at a table in the dining room finishing his breakfast. R2 started yelling out and swearing; R1 who was seated at a table parallel to R2, looked over at R1 and scowled. Licensed practical nurse (LPN)-M respectfully redirected the resident who apologized for his behavior. At 9:01 a.m., R2 again began swearing loudly in the dining room. Activity assistant (AA)-K looked at surveyor then stated they try to "curb" this behavior. AA-K then asked R1 to watch his language, R1 apologized then got up from the dining room table and walked independently with use of a two-wheeled walker to his room. R2's Service Addendum dated March 15, 2022, did not identify the resident's verbal behaviors. On December 13, 2022, at 5:07 p.m. registered nurse (RN)-B confirmed in the past few weeks R2 had exhibited an increase in voicing explicit words and singing out. RN-B further stated R2 had been resistive to being toileted by staff for a long time. RN-B confirmed R2's verbal and resistance to care behaviors were not included on his Service Addendum, nor were there interventions	02180		

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	31249	A. BUILDING: _____ B. WING _____	12/20/2022

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02180	Continued From page 29 to minimize the above behaviors for staff to implement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02180		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R3) who utilized bed rails. This resulted in an immediate order issued on December 12, 2022, at approximately 6:00 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at 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:	02310		

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 _____	12/20/2022

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02310	Continued From page 30 R3 On December 12, 2022, at approximately 2:00 p.m., R3's bed had a half bed rail on the right side. The surveyor grasped the bed rail and noted the bed rail to be secured to the bed and did not move when pulled and pushed on with force. R3 admitted February 23, 2016, with diagnoses including hearing loss. R3's service plan, dated September 29, 2022, indicated R3 received services including medication management and activities of daily living. R3's medical record lacked documentation of a bed rail assessment that included bed rail zone measurements. The licensee had no documentation of educating staff to notify the registered nurse (RN) of any changes regarding bed rails in the facility. On December 12, 2022, at approximately 2:00 p.m., RN-B acknowledged bed rails were in place for R3 and bed rail zone measurements had not been completed for R3's bed rails until after surveyors requested those measurements on December 12, 2022. Zone measurements on December 12, 2022: Zone 1-3.5 inches, Zone 2-0 inches, Zone 3-1.5 inches, Zone 4-0 inches. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the	02310		

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02310	Continued From page 31 rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's (resident's) physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The licensee's Resident Assistive Devices policy dated July 2022, directed facility clinical staff would be responsible for completing the appropriate assessments for bed rails and any device applied to a hospital style bed must comply with Food and Drug Administration requirements. No further information provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of correction order, tag identification 2310 was removed December 13, 2022, scope and level of noncompliance remained the same.	02310		

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

Type: Full
Date: *12/13/22*
Time: 11:30:00
Report: 1005221222

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: Yes

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.

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

AN IRREVERSIBLE REGISTERING THERMOMETER WAS ON SITE, BUT DID NOT WORK. REPLACE BATTERIES OR PROVIDE A NEW THERMOMETER.

Comply By: 12/20/22

6-300 Physical Facility Numbers and Capacities

6-301.11 ** Priority 2 **

MN Rule 4626.1440 Provide an adequate supply of hand soap at each handwashing sink or group of 2 adjacent handwashing sinks.

NO SOAP AVAILABLE AT THE HANDWASHING SINK NEXT TO THE PREP SINK.

Comply By: 12/13/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

THE WIPING CLOTH BUCKET WAS NEAR 0 PPM LACTIC ACID (S&S SANITIZER) BECAUSE THE DISPENSER AT THE 3-COMPARTMENT SINK IS NOT DISPENSING AT THE CORRECT CONCENTRATION. QUAT TABLETS ARE AVAILABLE THAT CAN BE USED UNTIL DISPENSER IS ADJUSTED.

Comply By: 12/13/22

4-500 Equipment Maintenance and Operation

4-501.11AB

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

THE ECOLAB SINK & SURFACE DISPENSER WAS NOT PROVIDING THE CORRECT CONCENTRATION OF SANITIZER. ESTABLISHMENT HAS QUAT TABLETS ON SITE THAT CAN BE USED IN WIPING CLOTH BUCKETS UNTIL IT IS REPAIRED. ALL DISHES ARE RUN THROUGH THE DISH MACHINE.

Comply By: 12/20/22

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

THERE IS A HEAVY BUILD-UP OF FOOD DEBRIS AND / OR MOLD ON THE WALK-IN COOLER RACKS. THERE IS SPILLED FOOD ON THE FLOOR OF THE WALK-IN COOLER NEAR THE MILK CRATES.

Comply By: 12/20/22

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 165 Degrees Fahrenheit
Location: KITCHEN DISH MACHINE
Violation Issued: No

Lactic Acid: = 452PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: Yes

Lactic Acid: = 452PPM at Degrees Fahrenheit
Location: 3-COMP DISPENSER
Violation Issued: Yes

Utensil Surface Temp.: = at 162 Degrees Fahrenheit
Location: MEMORY CARE DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Hold/CARROTS
Temperature: 166 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

Process/Item: Hot Hold/POTATOES
Temperature: 167 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

Process/Item: Hot Hold/CHICKEN
Temperature: 178 Degrees Fahrenheit - Location: STEAM TABLE
Violation Issued: No

Process/Item: Cold Hold/TOMATOES
Temperature: 32 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/LETTUCE
Temperature: 38 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/HOT DOG
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cooling/SAUSAGE
Temperature: 75 Degrees Fahrenheit - Location: PREP COOLER, 1.5 HOURS
Violation Issued: No

Process/Item: Hot Hold/HAMBURGER
Temperature: 203 Degrees Fahrenheit - Location: STOVETOP
Violation Issued: No

Process/Item: Cold Hold/AMBIENT
Temperature: <37 Degrees Fahrenheit - Location: COOK LINE UNDER COUNTER COOLER
Violation Issued: No

Process/Item: Hot Hold/BARLEY SOUP
Temperature: 167 Degrees Fahrenheit - Location: SOUP WARMER
Violation Issued: No

Process/Item: Cold Hold/ALMOND MILK
Temperature: 40 Degrees Fahrenheit - Location: SERVER UNDER COUNTER COOLER
Violation Issued: No

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

Process/Item: Cold Hold/PORK
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/CHICKEN
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/CHEESE
Temperature: 36 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/CABBAGE
Temperature: 35 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: MEMORY CARE UPRIGHT COOLER
Violation Issued: No

Process/Item: Hot Hold/BARLEY SOUP
Temperature: 150 Degrees Fahrenheit - Location: MEMORY CARE STEAM TABLE
Violation Issued: No

Process/Item: Hot Hold/CHICKEN
Temperature: 158 Degrees Fahrenheit - Location: MEMORY CARE STEAM TABLE
Violation Issued: No

Process/Item: Hot Hold/POTATOES
Temperature: 154 Degrees Fahrenheit - Location: MEMORY CARE STEAM TABLE
Violation Issued: No

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

INSPECTION COMPLETED WITH KITCHEN MANAGER AND DIRECTOR OF OPERATIONS, AND REVIEWED WITH HRD NURSE EVALUATOR ROBYN WOOLLEY.

DISCUSSED ALL ORDERS ON REPORT AS WELL AS COOLING, DATE-MARKING, BARE HAND CONTACT, AND EMPLOYEE ILLNESS.

THIS IS A COMMERCIAL KITCHEN WITH APPROVED FLOORS, WALLS, AND CEILINGS, AND ALL NSF OR EQUIVALENT EQUIPMENT.

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

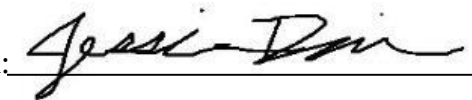
I acknowledge receipt of the Minnesota Department of Health inspection report number 1005221222 of 12/13/22.

Certified Food Protection Manager: ELIZABETH A. LITZELL

Certification Number: FM108736 Expires: 12/03/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
LIZ LITZELL
KITCHEN MANAGER

Signed: 
Jessica Davis
Public Health Sanitarian III
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