Electronically Delivered

July 22, 2025

Licensee
Summit Ridge Place
1325 Summit Avenue North
Sauk Rapids, MN 56379

RE: Project Number(s) SL30601016

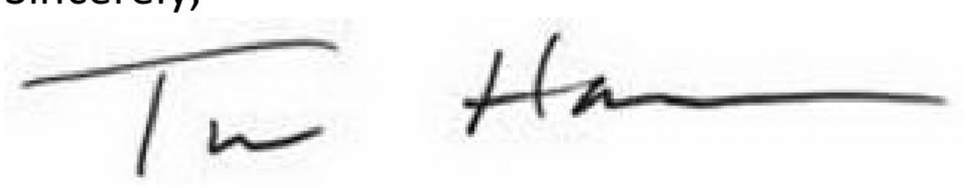
Dear Licensee:

On June 11, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on March 18, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD

Electronically Delivered

April 21, 2025

Licensee
Summit Ridge Place
1325 Summit Avenue North
Sauk Rapids, MN 56379

RE: Project Number(s) SL30601016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 18, 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.

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

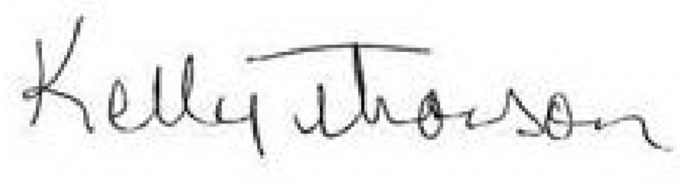
the website listed above.

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,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 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
	30601	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

(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: SL#30601016 On March 17, 2025, through March 18, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 12 residents; 12 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, but was not likely to cause serious injury, impairment, or death), and is 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 17, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents.	0 680		

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0 680	Continued From page 4 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 is 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: On March 18, 2025, at 9:36 a.m., assisted living director in residence (ALDIR)-A provided licensee's emergency preparedness plan dated June 1, 2024. The licensee's EPP plan lacked evidence of the following required content: - missing resident quarterly review On March 18, 2025, at 1:50 p.m., ALDIR-A stated she could not locate a missing resident policy. ALDIR-A stated she was not aware that the missing resident policy needed to be reviewed quarterly. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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:	0 775		

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0 775	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the Minnesota State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 18, 2024, from 10:00 a.m. to 11:30 a.m., the surveyor toured the facility with assisted living director in residence (ALDIR)-A and director of maintenance (DM)-H. The surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions: FIRE RESISTANT RATED DOORS: The closer arm was removed from the door closer mechanism on the fire-resistant rated door to the furnace room adjacent to apartment 12. The three pairs of fire resistant rated double doors into the dining room did not close and latch. Fire resistant rated doors are required to automatically close and latch to prevent the spread of flame and smoke in the event of a fire or similar emergency. EXIT DOORS AND LOCKING:	0 775		

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0 775	Continued From page 6 The exit doors from the locked memory care unit discharged into a locked exterior yard. The gate leading to the public way (sidewalk, driveway, street) had a coded lock, slide lock, and hasp lock with padlock installed preventing access to the public way. All marked exit doors are required to have exit paths maintained from the exit door through the exterior exit path to the public way without locks or latches that require keys, tools, or special knowledge. All the egress doors were equipped with electromagnetic locks. ALDIR-A and DM-H stated they did not have a remote emergency release button to release all the electromagnetic locks on the exit doors. The egress control locking system at all exterior doors shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock. These deficient conditions were visually verified at the time of discovery by ALDIR-A and DM-H accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
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) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 7 (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) Staff 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 staff 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 interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, to provide the required training, and to conduct evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 810		

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0 810	Continued From page 8 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 18, 2025, assisted living director in residence (ALDIR)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "9.06 Fire Policy", dated June 1, 2024, failed to include the following: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include the identification of any residents that needed assistance, any resident-specific procedures to staff for assisting residents during evacuation, nor	0 810		

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0 810	Continued From page 9 did it include instructions for staff to follow in case of relocation. On March 18, 2025, at 1:30 p.m., ALDIR-A stated they would develop their policy further. The policy reviewed was an unedited policy from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. ALDIR-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. ALDIR-A stated no current residents were capable of self preservation. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. ALDIR-A lacked documentation showing any training was offered or training was scheduled for a future date for employees on the fire safety and evacuation plan. On March 18, 2025, at 1:30 p.m., ALDIR-A stated they had not completed any training for staff or residents on the FSEP since they started in the position. ALDIR-A could not locate any records for training from prior administrator. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following:	01370		

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01370	Continued From page 10 (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 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	01370		

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	30601	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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01370	Continued From page 11 review, the licensee failed to ensure required training was completed for three of three employees (unlicensed personnel (ULP)-D, ULP-G and ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-D ULP-D was hired on March 26, 2024, to perform direct care services to residents. On March 17, 2025, at 8:24 a.m., through 8:55 a.m., the surveyor observed ULP-D administer medications to residents of the facility. ULP-G ULP-G was hired on May 3, 2023, to perform direct care services to residents. ULP-I ULP-I was hired on March 26, 2024, to perform direct care services to residents. ULP-D, ULP-G, and ULP-I's employee records lacked documentation of the following required training to be completed by ULP: - training on the prevention of falls for providers working with the elderly or individuals at risk of falls; - medication, exercise, and treatment reminders; - understanding appropriate boundaries between	01370		

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01370	Continued From page 12 staff and residents and the resident's family; and - awareness of commonly used health technology equipment and assistive devices. On March 18, 2025, at 1:35 p.m., licensed assisted living director in residence (LALDR)-A confirmed the topics are missing from the employee records and this is due to the prior management company not assigning the correct topics or creating the required training for the unlicensed staff. The licensee's 5.02 Competency Training Evaluations policy dated June 1, 2024, indicated training and competency evaluations for all ULP's will include: - Training on the prevention of falls; - Medication, exercise, and treatment reminders; - Understanding appropriate boundaries between staff and residents and the resident's family; and - Awareness of commonly used health technology equipment and assistive devices. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	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	01380		

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01380	Continued From page 13 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 required training was completed for three of three employees (unlicensed personnel (ULP)-D, ULP-G and ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-D ULP-D was hired on March 26, 2024, to perform direct care services to residents. On March 17, 2025, at 8:24 a.m., through 8:55 a.m., the surveyor observed ULP-D administer medications to residents of the facility. ULP-G ULP-G was hired on May 3, 2023, to perform direct care services to residents.	01380		

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01380	Continued From page 14 ULP-G's employee record lacked documentation of the following required training to be completed by ULP: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel. ULP-I ULP-I was hired on March 26, 2024, to perform direct care services to residents. ULP-D and ULP-I's employee records lacked documentation of the following required training to be completed by ULP: - observation, reporting, and documenting of resident status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. On March 18, 2025, at 1:35 p.m., licensed assisted living director in residence (LALDR)-A confirmed the topics are missing from the employee records and this is due to the prior management company not assigning the correct topics or creating the required training for the unlicensed staff. The licensee's 5.02 Competency Training Evaluations policy dated June 1, 2024, indicated training and competency evaluation for all unlicensed personnel providing assisted living services must include: - observing reporting and documenting resident	01380		

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01380	Continued From page 15 status; - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical; emotional, cognitive, and developmental needs of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=E	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.	01440		

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01440	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse completed delegated task supervision within 30 calendar days for two of two employees (unlicensed personnel (ULP)-D, ULP-I) who performed delegated tasks. 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: ULP-D ULP-D was hired on March 26, 2024, to perform direct care services to residents. On March 17, 2025, at 8:24 a.m., through 8:55 a.m., the surveyor observed ULP-D administer medications to residents of the facility. ULP-I ULP-I was hired on March 26, 2024, to perform direct care services to residents. ULP-D and ULP-I's records lacked evidence the registered nurse (RN) completed supervision of ULPs who performed delegated tasks within 30 calendar days.	01440		

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01440	Continued From page 17 On June 12, 2024, at 2:54 p.m., licensed assisted living director in residence (LALDR)-A stated some of the staff are missing the 30-day supervision and this is due to the previous nurse missing them. The licensee's 6.14 Supervision of Staff - Delegated Services policy dated June 1, 2024, indicated staff who provide delegated nursing or therapy tasks to residents at the licensee's communities will be supervised by an RN or appropriate licensed health professional where the services are being provided to verify that work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the task. Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working and/or 1st performs the delegated task for residents and thereafter as needed based on performance. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 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	01540		

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01540	Continued From page 18 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 observation, interview, and record review, the licensee failed to ensure the required eight (8) hours of dementia care training was completed for direct-care employees within 80 hours of employment start date for two of two employees (unlicensed personnel (ULP)-D,ULP-I). 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-D ULP-D was hired on March 26, 2024, to perform direct care services to residents. On March 17, 2025, at 8:24 a.m., through 8:55 a.m., the surveyor observed ULP-D administer medications to residents of the facility.	01540		

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01540	Continued From page 19 ULP-I ULP-I was hired on March 26, 2024, to perform direct care services to residents. ULP-D and ULP-I's employee records had five (5) hours of documented initial dementia care training. ULP-D and ULP-I's employee records lacked documentation of the required eight (8) hours of dementia care training to be completed within 80 hours of employment start date. On March 18, 2025, at 1:35 p.m., licensed assisted living director in residence (LALDR)-A stated she realized the previous management company did not assign the correct dementia training classes and has reassigned all the dementia training for all the staff to complete so she knows they all have the correct classes. The licensee's 5.03 Dementia Training policy dated June 1, 2024, indicated all staff of licensee's communities are required to complete dementia training at the time of hire and annually thereafter. Direct care employees will compete eight (8) hours of initial training within 80 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date	01640		

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01640	Continued From page 20 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, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan was developed for one of one resident (R3). 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:	01640		

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01640	Continued From page 21 R3 was admitted and began receiving services on October 24, 2023. R3's record lacked a service plan. R3's Treatment Assistant record, dated March 2025, indicated R3 received services to include assistance with housekeeping, laundry, medication administration, glucometer checks, meal reminders, vital sign monitoring, safety checks and behavior management. On March 18, 2025, at 1:50 p.m., assisted living director in residence (ALDIR)-A stated she was aware of the requirements of the service plan and believed they had been done by the previous LALD. She stated that several residents do not have a service plan in their medical record. The customized living tool from their county waiver care coordinator was being used in place of the service agreement. The licensee's Service Plan policy dated June 1, 2024, indicated all residents receiving assisted living services will have a service plan in place. Within 14 days after the date that services are first provided to a resident, [the facility] will finalize a written service plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility	01750		

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01750	Continued From page 22 must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of three unlicensed personnel (ULP-D) completed training and competency evaluations for medication administration prior to administering medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 March 26, 2024, to perform direct care services to residents. On March 17, 2025, at 8:24 a.m., through 8:55 a.m., the surveyor observed ULP-D administer medications to residents of the facility. ULP-D's employee record lacked documentation of completed training and competency evaluation	01750		

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01750	Continued From page 23 for medication administration. On March 18, 2025, at 12:10 p.m., ULP-D stated she was trained and demonstrated competency to the registered nurse on medication administration, she does not remember the nurses name but the nurse works for the company at another location and came to the facility to complete a training class with some of the staff. On March 18, 2025, at 1:35 p.m., licensed assisted living director in residence (LALDR)-A stated she agrees that ULP-D's employee record is missing the documentation that a nurse had completed the medication training and competency evaluation, and this is more than likely due to a documentation error by the nurse that had completed it. The licensee's 7.11 Medications and Treatment-Administration and Delegation policy dated June 1, 2024, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, the community will ensure that the registered nurse has: - instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures. Written records, sign by a RN, shall be maintained regarding ULP training and competency testing of delegated medication administration and treatment/therapy. No further information was provided.	01750		

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01750	Continued From page 24 TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least every 12 months for two of 12 residents (R2 and R3). 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: R2 R2 was admitted to the licensee on August 3, 2022. R2's Service Plan dated October 21, 2023, indicated R2 received services to include medication administration, bathing assistance, behavior management, activity assistance, safety checks and vital sign monitoring.	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

(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
01830	Continued From page 25 R2's March 2025, medication administration record showed the following medications: -acetaminophen 1000 milligrams (mg) three times daily -amlodipine besylate 5mg daily -Breo Ellipta 100-25 micrograms (mcg) 1 puff daily -buspirone 30 mg daily -buspirone 10 mg daily -carvedilol 25 mg twice daily -clotrim-beta 1%-0.005% twice daily -escitalopram 10 mg daily -estradiol 10 mcg twice weekly -famotidine 20 mg daily -gabapentin 300 mg three times daily - levothyroxine 112 mcg daily -lidocaine 4% daily -losartan 100 mg daily -methocarbamol 500 mg twice daily -mirabegron ER 25 mg daily -torsemide 40 mg daily -trazodone 50 mg daily -ammonium lactate 12% daily -melatonin 3 mg daily -albuterol sulfate hydrofluoroalkane 90 mcg every 6 hours as needed -antifungal 2% every 12 hours as needed -Benadryl 1-0.1% three times daily as needed -diclofenac sodium 1% 4 grams twice daily as needed -diphenhydramine 50 mg every 6 hours as needed -hydroxyzine HCL 25mg three times daily as needed -loperamide 2 mg 1-4 tablets per day as needed per instructions R3 R3 was admitted to the licensee on October 24,	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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01830	Continued From page 26 2023. R3's record lacked a service plan. R3's Elderly Waiver Residential Service Plan indicated R3 received services to include homemaking, activity assistance, medication administration and behavior management. R2's March 2025, medication administration record showed the following medications: -levothyroxine 25 mcg daily -ammonium Lactate 12% twice daily -baclofen 5 mg daily -Cerovite Senior 1 tab daily -donepezil 10 mg twice daily -ferrous sulfate 325 mg twice daily -folic acid 1 mg daily -furosemide 20 mg twice daily -memantine HCL 10 mg twice daily -pantoprazole 40 mg daily -rosuvastatin 20 mg daily -spironolactone 50 mg daily -vitamin D2 1000 mcg daily -duloxetine 20m g daily -ammonium lactate 12% twice daily -metformin HCL 1000 mg daily -trazodone 50 mg daily -albuterol sulfate hydrofluoroalkane 90 mcg every 4 hours as needed -DuoNeb 1 vial twice daily as needed -ipratropium-albuterol 0.5-3mg/3ml twice daily as needed -acetaminophen 650mg three times daily as needed -baclofen 5 mg daily as needed -diclofenac sodium 1% 2 grams (gm) four times daily as needed -ibuprofen 400 mg three times daily as needed -triamcinolone 0.1% twice daily as needed -triamcinolone 0.5% twice daily as needed	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	03/18/2025

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SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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01830	Continued From page 27 R2's record included signed medication orders dated August 11, 2023. No annual orders were obtained. R3's record included signed medication orders dated October 23, 2023, to October 23, 2024. No annual orders were obtained. On March 18, 2025, registered nurse (RN)-F stated R2 and R3's record lacked current prescriptions. She stated there was an oversight by previous staff and many of the yearly orders and new prescription orders had not been obtained. The licensee's Medication and Treatments policy dated June1, 2024, indicated medication and treatment/therapy orders will be sent to the resident's authorized prescriber for signatures at least every 12 months or more frequently if medications or services are new or changed. Signed medication and treatment order renewals will be placed in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	03/18/2025

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01950	Continued From page 28 appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for blood glucose monitoring for one of three employees unlicensed personnel (ULP)-D) who provided direct care to R3. 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: R3 was admitted to the licensee on October 24, 2023, with a diagnosis of liver cirrhosis. R3's Service Plan dated November 24, 2023, indicated R3 received services to include homemaking, medication administration, blood	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

(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
01950	Continued From page 29 glucose monitoring, vital sign monitoring, and safety checks. R3's Services Delivered dated March 1, 2025, through March 16, 2025, indicated ULP-D provided blood glucose service to R3 on March 3, 8, 9, 11, 12, 13, and 17, 2025. ULP-D was hired on March 26, 2024, to perform direct care services to residents. ULP-D's record lacked documentation to indicate ULP-D had received training and demonstrated competency for blood glucose monitoring. On March 18, 2025, at 12:10 p.m., ULP-D stated she was never trained or competency evaluated by a nurse on blood glucose monitoring, but she knew how to do this from a previous job she had. On March 18, 2025, at 1:35 p.m., licensed assisted living director in residence (LALDR)-A stated she agreed ULP-D's record is missing documentation of ULP-D having training or competency evaluation for blood glucose monitoring and this is more than likely due to a documentation error by the nurse that had completed it. The licensee's 7.11 Medications and Treatment-Administration and Delegation policy dated June 1, 2024, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, the community will ensure that the registered nurse has: - instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30601	A. BUILDING: _____ B. WING _____	03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT RIDGE PLACE	1325 SUMMIT AVENUE NORTH SAUK RAPIDS, MN 56379

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01950	Continued From page 30 demonstrated the ability to competently follow the procedures. Written records, sign by a RN, shall be maintained regarding ULP training and competency testing of delegated medication administration and treatment/therapy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a	02040		

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02040	Continued From page 31 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 March 18, 2025, assisted living director in residence (ALDIR)-A provided documents on the hazard vulnerability assessment (HVA). The licensee's HVA, titled "7.02 Hazard Vulnerability Analysis", undated, failed to include the following: The HVA included the identification of global risk factors like severe weather, wild fires, epidemics, systems failures, and civil disturbances but failed to identify any potential hazards or risks that were specific to the facility's neighborhood, grounds, building, or population. The HVA did not include a section that identified specific mitigation factors to be in place for any hazards or risks that were identified in the HVA. On March 18, 2025, at 1:30 p.m. ALDIR-A stated they had not performed a hazard vulnerability assessment with mitigation factors on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		

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

Type: Full
Date: *03/17/25*
Time: 10:30:16
Report: 1046251059

Food and Beverage Establishment Inspection Report

Location:
Summit Ridge Place
1325 Summit Avenue North
Sauk Rapids, MN56379
Benton County, 05

Establishment Info:
ID #: 0037540
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3203161604
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.

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.
THE WALL AROUND THE MOP SINK HAS WATER DAMAGE AND IS DEGRADING. REPAIR WALL.

Comply By: 09/17/25

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: SOUR CREAM
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK
Violation Issued: No

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

Type: Full
Date: *03/17/25*
Time: 10:30:16
Report: 1046251059
Summit Ridge Place

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1046251059 of 03/17/25.

Certified Food Protection Manager: Jessica R. Holloway

Certification Number: 48321 Expires: 06/04/27

Inspection report reviewed with person in charge and emailed.

Signed:_____
Establishment Representative

Signed:_____
Nicole Larrison
Public Health Sanitarian
St. Cloud
320-472-0042
nicole.larrison@state.mn.us

Report #: 1046251059

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 03/17/25
Time In 10:30:16
Time Out

	Address	City/State	Zip Code	Telephone
Summit Ridge Place	1325 Summit Avenue North	Sauk Rapids, MN	56379	3203161604

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037540		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

Compliance Status						COS	R
Supervision							
1	(IN)	OUT			PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A		Certified food protection manager, duties		
Employee Health							
3	(IN)	OUT			Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT			Proper use of reporting, restriction & exclusion		
5	(IN)	OUT			Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices							
6	(IN)	OUT		N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT		N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands							
8	(IN)	OUT		N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT			Adequate handwashing sinks supplied/accessible		
Approved Source							
11	(IN)	OUT			Food obtained from approved source		
12	IN	OUT	N/A	(N/O)	Food received at proper temperature		
13	(IN)	OUT			Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A)	N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination							
15	(IN)	OUT	N/A	N/O	Food separated and protected		
16	(IN)	OUT	N/A		Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT			Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status						COS	R
Time/Temperature Control for Safety							
18	IN	OUT	N/A	(N/O)	Proper cooking time & temperature		
19	IN	OUT	N/A	(N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	(N/O)	Proper cooling time & temperature		
21	IN	OUT	N/A	(N/O)	Proper hot holding temperatures		
22	(IN)	OUT	N/A		Proper cold holding temperatures		
23	(IN)	OUT	N/A	N/O	Proper date marking & disposition		
24	IN	OUT	(N/A)	N/O	Time as a public health control: procedures & records		
Consumer Advisory							
25	IN	OUT	(N/A)		Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations							
26	IN	OUT	(N/A)		Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances							
27	IN	OUT	(N/A)		Food additives: approved & properly used		
28	(IN)	OUT			Toxic substances properly identified, stored, & used		
Conformance with Approved Procedures							
29	IN	OUT	(N/A)		Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
Safe Food and Water				
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	(IN) OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 03/18/25

Inspector (Signature)