Electronically Delivered

April 24, 2024

Licensee
Cedar Ridge Place
7115 Wayzata Boulevard
Saint Louis Park, MN 55426

RE: Project Number(s) SL31139015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 4, 2024, 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 . . ."

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessica Sellner, Supervisor
State Rapid Response Team
Email: jessica.sellner@state.mn.us
Telephone: 320-223-7370 Fax: 1-800-337-9238

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31139	A. BUILDING: _____ B. WING _____	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE PLACE	7115 WAYZATA BOULEVARD SAINT LOUIS PARK, MN 55426

(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 ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL#31139015 On April 2, 2024 to April 4, 2024, the Minnesota Department of Health conducted a CHOW (change of ownership) survey at the above provider, and the following correction orders are issued. At the time of the survey and investigation, there were 20 residents receiving services under the provider's Assisted Living Facility with Dementia Care license.	0 000		
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: (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:	0 480		

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0 480	Continued From page 1 Based on observation, interview, and record review, the licensee failed to comply with Minnesota Food Code, Chapter 4626. This had the potential to affect all #20 residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports dated April 2, 2024. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 480		
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 2 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 April 4, 2024, at 11:00 a.m., survey staff toured the facility with the interim community director (ICD)-E. During the facility tour, survey staff observed the following items: In the dining room on level 3, there was a gap between the perimeter of the sprinkler pipe and the wall, and the escutcheon was not installed directly against the wall. In resident unit 22 on level 3, survey staff observed the following items: - In the bathroom, the radiant heater baseboard was missing cover plates and an end cap, exposing sharp metal edges; the light fixture over the vanity did not work, and the ceiling-mounted exhaust fan was covered with thick dust. - In the living room, the ceiling-mounted fan was covered with thick dust. - In the resident's sleeping room, the gypsum wall was heavily damaged, and the core framings were exposed	0 800		

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0 800	Continued From page 3 In the laundry room on level 2, it was observed the ceiling-mounted exhaust fan and walls were covered with thick dust. In the staff office on level 2, it was observed that extensive mold or similar black substance on the supply air grille. Mold in the room housed by air distribution equipment has the potential to circulate mold throughout the floor served by that equipment. In the laundry room on level 1, it was observed the ceiling-mounted exhaust fan was covered with thick dust, and the floor was stained with sticky substances. In the kitchen on level 1, it was observed that black substances were on the supply air grilles. It was also observed that the kitchen door to the rated stair was propped open with a wood wedge. The door wedge would prevent the doors from closing properly in the event of a fire. During the interview on April 4, 2024, at 12:00 p.m., ICD-E visually verified these deficient findings at the time of discovery and verified these deficient findings were not a good repair regard to the safety of the residents. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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0 810	Continued From page 4 (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 the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and failed to provide the required drills. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 5 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 April 4, 2024, at 1:00 p.m., regional director of clinical (RDC)-D and interim community director (ICD)-E provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP and the posted evacuation plans did not show the location and number of resident rooms. During the facility tour with RDC-D on April 4, 2024, at 11:00 a.m., it was observed that the evacuation plan was not posted on the ground level. DRILLS Record review of the available documentation indicated the licensee did not conduct fire drills for employees twice per year per shift as required by statute. Provided documentation indicated that the drills were conducted every month as required but failed to provide drills for the night shift. During the interview on April 4, 2024, at 1:00 p.m., RDC-D stated that the previous director resigned the week before and did not transfer all	0 810		

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0 810	Continued From page 6 records. RDC-D verified that there were no further documented drills for the facility and verified the facility provided fire drills for the a.m. shift and p.m. shift only, according to the record. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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 hazard vulnerability assessment or safety risk assessment of the physical environment 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 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	02040		

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02040	Continued From page 7 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: A record review of the available documentation and interview was conducted on April 4, 2024, at 1:00 p.m. with the regional director of clinical (RDC)-D and interim community director (ICD)-E on the hazard vulnerability assessment for the physical environment of the facility. The record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During the interview on April 4, 2024, at 1:00 p.m., RDC-D stated that the licensee had not performed a hazard vulnerability assessment for the physical environment on or around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

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

Type: Full
Date: *04/02/24*
Time: 11:00:00
Report: 1005241084

Food and Beverage Establishment Inspection Report

Location:
Cedar Ridge Place
7115 Wayzata Boulevard
St Louis Park, MN55426
Hennepin County, 27

Establishment Info:
ID #: 0039377
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7633771800
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

IN THE "TRUE" REACH-IN COOLER, RAW BACON WAS STORED OVER CARTONS OF JUICE AND MILK. KEEP RAW ANIMAL FOODS BELOW READY-TO-EAT FOODS. CORRECTED ON SITE.

Comply By: 04/02/24

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

THE DISH MACHINE WAS RUN THREE TIMES AND THE HIGHEST UTENSIL SURFACE TEMPERATURE ACHIEVED WAS 155 DEGREES F. USE THE 3-COMP SINK FOR DISHES UNTIL THE DISH MACHINE IS REPAIRED.

Comply By: 04/02/24

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.

THERE IS NO DEVICE ON SITE TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN

THE DISH MACHINE. PROVIDE TEMPERATURE STRIPS OR A MAXIMUM REGISTERING THERMOMETER TO VERIFY THAT THE UTENSIL SURFACE TEMPERATURE IS 160 DEGREES F OR ABOVE.

Comply By: 04/09/24

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.

DISH MACHINE RINSE GAUGE HAS A MINIMUM REQUIRED TEMPERATURE OF 180 DEGREES F BUT WAS ONLY 120dF, AND THE UTENSIL SURFACE TEMPERATURE PROVIDED WAS ONLY 155dF INSTEAD OF THE MINIMUM OF 160dF. USE 3-COMP SINK TO CLEAN DISHES UNTIL DISH MACHINE IS REPAIRED

Comply By: 04/02/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO SIGN IS POSTED AT THE HANDWASHING SINK BY THE STOVE.

Comply By: 04/09/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: 3-COMP DISPENSER
Violation Issued: No

Quaternary Ammonia: = 200+PPM at Degrees Fahrenheit
Location: MOP SINK DISPENSER
Violation Issued: No

Utensil Surface Temp.: = at 155 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Cold Hold/TURKEY
Temperature: 39 Degrees Fahrenheit - Location: REACH-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/SOUR CREAM
Temperature: 41 Degrees Fahrenheit - Location: REACH-IN COOLER
Violation Issued: No

Process/Item: Cold Hold/BACON
Temperature: 40 Degrees Fahrenheit - Location: REACH-IN COOLER
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: Hot Hold/SWEET POTATO
Temperature: 138 Degrees Fahrenheit - Location: FOOD WARMER
Violation Issued: No

Process/Item: Hot Hold/PORK
Temperature: 142 Degrees Fahrenheit - Location: FOOD WARMER
Violation Issued: No

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

INSPECTION COMPLETED WITH KITCHEN MANAGER. DISCUSSED ALL ORDERS ON REPORT.

THE PREVIOUS MN CFPM JUST LEFT LAST WEEK, AND THE CURRENT KITCHEN MANAGER HAS ONLY THE SERV SAFE CERTIFICATE. PER FOOD CODE, ESTABLISHMENT HAS 60 DAYS TO EMPLOYEE A NEW MN CFPM. INFORMATION WILL BE EMAILED WITH REPORT.

REVIEWED SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT TO MAINTAIN AN EMPLOYEE ILLNESS LOG OF THOSE INSTANCES WHEN EMPLOYEES ARE ILL WITH VOMITING OR DIARRHEA "AND" IMMEDIATELY EXCLUDE FROM THE FOOD ESTABLISHMENT ANY FOOD EMPLOYEE ILL WITH VOMITING OR DIARRHEA. EMPLOYEES MUST BE EXCLUDED FOR AT LEAST 24 HOURS AFTER LAST SYMPTOM.

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 1005241084 of 04/02/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
MYRIAM RODRIGUEZ
KITCHEN MANAGER

Signed:_____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us