



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 4, 2025

Licensee
Meadow Ridge Senior Living
7475 Country Club Drive
Golden Valley, MN 55427

RE: Project Number(s) SL31962016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 3, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

Level 5: a fine of \$5,000 per

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

St - 0 - 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.

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To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

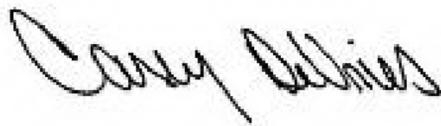
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms 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,



Casey DeVries, Supervisor

State Evaluation Team

Email: Casey.DeVries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

KKM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31962	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2025
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NAME OF PROVIDER OR SUPPLIER MEADOW RIDGE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7475 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427
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(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	<p>Initial Comments</p> <p>***ATTENTION***</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>SL31962016-0</p> <p>On June 2, 2025, through June 3, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 98 residents; all 98 receiving services under the Assisted Living Facility with Dementia Care license.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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0 480	<p>Continued From page 1</p> <p>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.</p> <p>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(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;</p> <p>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are</p>	0 480		

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0 480	<p>Continued From page 2</p> <p>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.</p> <p>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 had the potential to affect all residents of the assisted living facility.</p> <p>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).</p> <p>The findings include:</p> <p>Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 2, 2025, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on June 2, 2025.</p>	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	<p>144G.41 Subd. 3 Infection control program</p> <p>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.</p> <p>(b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.</p> <p>(c) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control related to hand hygiene for one of two employees (unlicensed personnel (ULP)-B).</p> <p>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).</p> <p>The findings include:</p>	0 510		

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0 510	<p>Continued From page 4</p> <p>On June 2, 2025, at 11:50 a.m., the surveyor observed ULP-B administer medications for R2. The surveyor observed ULP-B rinse their hands with water without soap in the kitchen sink. ULP-B stated they did not have soap in the room and then continued to rinse their hands without soap. ULP-B dried their hands with a paper towel and applied gloves to both hands. The surveyor observed a bottle of hand sanitizer on the kitchen counter next to the sink which ULP-B did not use. With soiled gloves, ULP-B completed a blood glucose (BG) check. ULP-B removed their gloves then performed hand hygiene using the bottle of hand sanitizer next to the sink; it was the first time ULP-B performed proper hand hygiene during the observation. ULP-B applied gloves and administered R2's insulin, removed their gloves, then rinsed their hands in the sink with water without using soap for a second time. With soiled hands, ULP-B left the room and went to the medication cart where they handled various items and touched the surfaces of the medication cart.</p> <p>On June 2, 2025, at 12:00 p.m., ULP-B stated they normally used soap and water to wash their hands but since there wasn't any soap in the room, they just used water. ULP-B stated, "I did use hand sanitizer, didn't you see me?" The surveyor stated ULP-B did use hand sanitizer one time during after they removed their gloves after they checked R2's BG, otherwise they just used water without soap. ULP-B again stated they normally used soap but since they were out of soap in the room, they just used water. ULP-B stated they were trained to use soap when washing their hands. ULP-B stated they should have used the available hand sanitizer.</p> <p>On June 2, 2025, at 12:05 p.m., clinical nurse</p>	0 510		

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0 510	<p>Continued From page 5</p> <p>supervisor (CNS)-A stated ULP-B was trained to wash their hands with soap and water. CNS-A stated ULP-B should have used soap and water, if soap was not available, they should have used the hand sanitizer available in the room. CNS-A stated if soap and sanitizer were not available ULP-B should have stopped the process and addressed the issue and gotten soap before proceeding with hand washing.</p> <p>The Center for Disease Control (CDC) Hand Hygiene Guidance last reviewed on April 12, 2024, indicated The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings:</p> <p>"Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications:</p> <ul style="list-style-type: none"> - Immediately before touching a patient - Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices - Before moving from work on a soiled body site to a clean body site on the same patient - After touching a patient or the patient's immediate environment - After contact with blood, body fluids, or contaminated surfaces - Immediately after glove removal <p>Healthcare facilities should:</p> <ul style="list-style-type: none"> - Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations - Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled 	0 510		

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0 510	<p>Continued From page 6</p> <p>- Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands."</p> <p>The licensee's 8.09 Hand Washing policy dated August 1, 2021, indicated: Hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations. When Hands Should be Washed Hand washing shall be performed between resident cares and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated:</p> <ul style="list-style-type: none"> · Before and after direct contact with a resident · If moving from a contaminated-body site to a clean-body site during resident care · After contact with environmental surfaces or equipment in the immediate vicinity of the resident · After removing gloves or gowns · Before, during, and after preparing food · Before and after eating food · Before and after caring for someone who is sick · Before and after treating a cut or wound · After using the toilet · After blowing your nose, coughing, or sneezing · After touching an animal or animal waste 	0 510		

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0 510	<p>Continued From page 7</p> <ul style="list-style-type: none"> · After handling pet food or pet treats · After touching garbage <p>Equipment Needed:</p> <ul style="list-style-type: none"> · Soap · Water · Paper towels <p>Steps:</p> <ol style="list-style-type: none"> 1. Stand away from the sink. Hands and sleeves must not touch the sink 2. Turn on water and adjust to a comfortably warm temperature 3. Wet hands and wrists 4. Apply soap over hands and wrists, working into a generous lather by scrubbing vigorously 5. Use friction and scrub vigorously for at least 20 seconds (long enough to sing ' Happy Birthday ' twice) 6. Be sure to clean beneath the fingernails, around the knuckles and along the sides of the fingers and hands <p>Assisted Living License Resource Manual © June 2021 Care Providers of Minnesota Page 2 of 2</p> <ol style="list-style-type: none"> 7. Rinse hands and wrists completely under running water to wash away suds and microorganisms 8. DO NOT TURN FAUCETS OFF WITH CLEAN HANDS - see #10 below 9. Pat hands and wrists dry with a paper towel. It is unacceptable to use resident towels for drying hands 10. Turn off water using a clean paper towel to prevent recontamination of the hands 11. If leaving a washroom/restroom, use paper towels to grasp door handle upon exit to prevent recontamination of clean hands <p>Hand Hygiene and Gloves When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after</p>	0 510		

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0 510	<p>Continued From page 8</p> <p>removing gloves. Alcohol-Based Hand Sanitizers (ABHS) ABHS should not be used as a replacement for proper hand washing when hands are visibly soiled. However, if hands are not visibly soiled, or soap and water are not available, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used to quickly reduce the number of germs on hands. There is no limit to the number of times you use ABHS before you must use soap and water. Soap and water must be used when hands are visibly soiled, after using the bathroom, prior to preparing food, after completing cares for someone with c. diff or norovirus. Steps: 1. Follow the product directions regarding how much sanitizer to use. Apply enough sanitizer to the palm of your hand to wet your hands completely. 2. Rub hands together and then rub sanitizer all over the tops of your hands, in between your fingers and the area around and under the fingernails. 3. Continue rubbing until the hands are dry-at least 15 seconds if an adequate amount of sanitizer was used. 4. Do not rinse hands or use a towel to dry them after using hand sanitizer." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 510		
0 660 SS=D	<p>144G.42 Subd. 9 Tuberculosis prevention and control</p> <p>(a) The facility must establish and maintain a</p>	0 660		

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0 660	<p>Continued From page 9</p> <p>comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an employee's TB test chest Xray (CXR) was completed within 90 days of a documented positive Mantoux skin test or blood test one of two employees (unlicensed personnel (ULP)-B).</p> <p>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).</p> <p>The findings include:</p> <p>The licensee's Facility TB Risk Assessment dated June 2, 2025, indicated the facility was at a low risks level.</p>	0 660		

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NAME OF PROVIDER OR SUPPLIER MEADOW RIDGE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7475 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427
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(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
0 660	<p>Continued From page 10</p> <p>ULP-B was hired on March 2, 2020, to provide direct cares to residents.</p> <p>On June 2, 2025, at 11:50 a.m., the surveyor observed ULP-B administer insulin for R3.</p> <p>ULP-B's employee record included a Physicians Chest X-Ray Reading form dated January 8, 2020, which indicated ULP-B was negative for active TB.</p> <p>ULP-B's employee record lacked evidence of a Mantoux skin test or blood test completed within 90 days prior to ULP-B's CXR on January 8, 2020.</p> <p>On June 3, 2025, at 12:35 p.m., licensed assisted living director (LALD)-D stated they did not have a positive TB test for ULP-B, only the CXR. LALD-D stated they were aware of the TB testing requirements.</p> <p>The Minnesota Department of Health TB FAQ dated June 2, 2025, indicated if the health care worker had a prior positive TB test result, and they only have the CXR but no other test documentation, then they need to take a new TB test. If the result is positive, a new CXR needs to be completed. The CXR needs to be done within 90 days of the positive test date or dated any time after the positive test date.</p> <p>The licensee's 8.16 Tuberculosis Screening policy dated July 16, 2024, indicated: "Staff Screening Staff whose essential job functions require to work within the same air space of residents will be screened and tested for tuberculosis prior to reporting to work. Baseline (upon hire) screening will be completed, but serial (annual) screening</p>	0 660		

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0 660	<p>Continued From page 11</p> <p>will only be required with increased occupational risk or exposure.</p> <p>Screening will be conducted as follows:</p> <ol style="list-style-type: none"> 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Screening will be completed on employees who have traveled to for more than a month in Latin America, (South and Central America, Mexico and the Caribbean), Eastern Europe, Africa, or Asia." <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> 	0 660		
0 775 SS=F	<p>144G.45 Subd. 2. (a) Fire protection and physical environment</p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>This MN Requirement is not met as evidenced by:</p>	0 775		

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0 775	<p>Continued From page 12</p> <p>Based on observation and interview, the licensee failed comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents.</p> <p>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).</p> <p>The findings include:</p> <p>On June 2, 2025, the surveyor toured the facility with maintenance director (MD)-F. The following was observed.</p> <p>FIRE DOOR OPERATION: There were multiple fire doors in the following locations that would not close and latch automatically: assisted living first floor laundry room, Activity room door by south stair, assisted living second floor laundry, resident room 218 entry door, third floor laundry room, and resident room 318 entry door.</p> <p>Swinging fire doors shall close from the full-open position and latch automatically.</p> <p>EXIT OBSTRUCTION: There were med carts stored in the common hallway leading to the east stair on all floors reducing the corridor width by approximately 24 inches. MD-F stated that the med carts are normally stored in the hallway in that location.</p>	0 775		

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0 775	<p>Continued From page 13</p> <p>The minimum width or required capacity of a means of egress system shall not be diminished along the path of egress travel.</p> <p>REQUIRED FIRE STOPPING: In the activity room electrical closet there was missing ceiling fire stopping.</p> <p>Where required when the building was originally constructed, materials and systems used to protect joints and voids shall be maintained. The materials and systems shall be securely attached to or bonded to the adjacent construction, without openings visible through the construction.</p> <p>CONTROLLED EGRESS DOORS: When interviewed about the magnetic locking system in the memory care unit MD-F stated that they were not aware of a button or switch in an approved location that would release the magnetic locks on the exit doors. A switch or button was not able to be located during the tour.</p> <p>The egress control locking system 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.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 775		
0 810 SS=F	<p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:</p>	0 810		

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0 810	<p>Continued From page 14</p> <p>(1) location and number of resident sleeping rooms;</p> <p>(2) staff actions to be taken in the event of a fire or similar emergency;</p> <p>(3) fire protection procedures necessary for residents; and</p> <p>(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.</p> <p>(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.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(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.</p> <p>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 and provide the required training. This had the potential to directly affect all residents, staff, and visitors.</p>	0 810		

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0 810	<p>Continued From page 15</p> <p>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 potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On June 2, 2025, licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p>FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "9.06 Fire Policy", dated July 25, 2021, failed to include the following:</p> <p>The FSEP included standard employee procedures but 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate). The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility.</p> <p>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.</p> <p>On June 2, 2025, LALD-D stated they understood</p>	0 810		

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0 810	Continued From page 16 the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. The licensee lacked documentation showing any training was offered or training was scheduled for a future date for staff on the fire safety and evacuation plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of	01470		

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01470	<p>Continued From page 17</p> <p>complaints, and where to report complaints, including information on the Office of Health Facility Complaints;</p> <p>(8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and</p> <p>(9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure.</p> <p>(b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;</p> <p>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by:</p>	01470		

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01470	<p>Continued From page 18</p> <p>Based on observation, interview, and record review, the licensee failed to ensure employees completed required orientation before providing services for two of two unlicensed direct care employees (unlicensed personnel (ULP)-B, ULP-C).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-B ULP-B was hired on March 2, 2020, to provide direct cares to residents.</p> <p>On June 2, 2025, at 11:50 a.m., the surveyor observed ULP-B administer insulin for R3.</p> <p>ULP-B's employee record included a Training and Orientation form which indicated ULP-B received orientation on an overview of home care statutes on June 22, 2020.</p> <p>ULP-B's employee record lacked evidence ULP-B received orientation to assisted living statutes.</p> <p>ULP-C ULP-C was hired on November 18, 2015, to provide direct cares to residents.</p> <p>ULP-C's employee record included an Overview of Home Care and housing with Services Statutes - Post Test form which indicated ULP-C received</p>	01470		

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01470	<p>Continued From page 19</p> <p>orientation on an overview of home care statutes dated March 4, 2020.</p> <p>ULP-C's employee record lacked evidence ULP-C received orientation to assisted living statutes.</p> <p>On June 3, 2025, vice president of operations (VPO)-E stated ULP-B and ULP-C received assisted living statute orientation and provided the above-mentioned home care statute orientation documentation. The surveyor explained the orientation documents were for home care statutes in 2020 prior to regulation changes made on August 1, 2021; staff hired prior to August 1, 2021, would have required them to receive new orientation on the assisted living statutes. VPO-E stated they were in the process of implementing new training and utilizing different training modules through Educare (online training platform) to cover the required orientation topics. VPO-E stated not all employees had completed the new training implemented.</p> <p>The licensee's 5.01 Orientation to Staff and Supervisors & Content policy dated August 1, 2021, indicated, "All Meadow Ridge Senior Living employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents." It further indicated orientation must contain, "An overview of the appropriate Assisted Living statutes and rules."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01470		

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01500	Continued From page 20	01500		
01500 SS=D	<p>144G.63 Subd. 5 Required annual training</p> <p>(a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:</p> <p>(1) training on reporting of maltreatment of vulnerable adults under section 626.557;</p> <p>(2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;</p> <p>(3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases;</p> <p>(4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;</p> <p>(5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and</p> <p>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.</p> <p>(b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.</p>	01500		

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01500	<p>Continued From page 21</p> <p>Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics:</p> <p>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;</p> <p>(2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or</p> <p>(3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment on required annual training topics for one of two employees who were employed more than 12 months (unlicensed personnel (ULP)-C).</p> <p>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).</p> <p>The findings include:</p>	01500		

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01500	<p>Continued From page 22</p> <p>ULP-C was hired on November 18, 2015, to provide direct cares to residents.</p> <p>ULP-C's Educare (online training platform) transcript and employee record lacked eight hours of annual training to include the following topics: - review of policies and procedures.</p> <p>On June 3, 2025, at 12:35 p.m., licensed assisted living director (LALD)-D stated they were unable to locate policy and procedure annual training for ULP-C and were unsure if they had completed the training. LALD-D stated they were trying to incorporate Educare into all of their annual training and wanted to use it for policy and procedure training as well. LALD-D stated they were in the process of implementing a new annual training procedure where all employees completed trainings at the same time each year instead of having employees complete it on their work anniversary, so training does not get missed. LALD-D stated they used Educare to complete all annual trainings.</p> <p>The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated: "The following training elements MUST be included every 12 months to all staff who performs direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal</p>	01500		

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(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
01500	<p>Continued From page 23</p> <p>of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases</p> <p>4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders</p> <p>5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures</p> <p>6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01500		
01540 SS=D	<p>144G.64 (a) (3) Training in Dementia, Mental Illness, and De-</p> <p>(3) for assisted living facilities with dementia care, direct-care staff 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, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a</p>	01540		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31962	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2025
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NAME OF PROVIDER OR SUPPLIER MEADOW RIDGE SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 7475 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427
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01540	<p>Continued From page 24</p> <p>supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two hours of required annual dementia care training was completed for one of two direct-care employees (unlicensed personnel (ULP)-B).</p> <p>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).</p> <p>The findings include:</p> <p>ULP-B was hired on March 2, 2020, to provide direct cares to residents.</p> <p>ULP-B's Educare transcript (online training platform) indicated ULP-B completed 1.5 hours of annual dementia training on January 30, 2025; annual dementia training was previously completed on September 22, 2023.</p> <p>On June 2, 2025, at 11:50 a.m., the surveyor</p>	01540		
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 31962	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/03/2025
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01540	<p>Continued From page 25</p> <p>observed ULP-B administer insulin for R3. ULP-B stated they completed their required annual training in Educare where the trainings were assigned for them.</p> <p>On June 3, 2025, at 12:35 p.m., licensed assisted living director (LALD)-D stated ULP-B was 0.5 hours short on their annual dementia training and would have them complete it immediately. LALD-D stated they were in the process of implementing a new annual training procedure where all employees completed trainings at the same time each year instead of having employees complete it on their work anniversary, so training does not get missed. LALD-D stated they used Educare to complete all annual trainings.</p> <p>The licensee's 5.06 Annual Required Staff Training policy dated August 1, 2021, indicated: "The following training elements MUST be included every 12 months to all staff who performs direct care services:</p> <ol style="list-style-type: none"> 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases 4. Effective approaches to use to problem solve when working with a resident's challenging 	01540		

Minnesota Department of Health

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01540	Continued From page 26 behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under	01620		

Minnesota Department of Health

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01620	<p>Continued From page 27</p> <p>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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment 14 days after admission for one of two residents (R2).</p> <p>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).</p> <p>The findings include:</p> <p>R2 was admitted to the licensee on June 25, 2024.</p> <p>R2's Service Plan dated March 11, 2025, indicated R2 received services for bathing assistance, medication setup, laundry, and vital signs.</p> <p>R2's Admission Assessment was completed on June 25, 2024. R2's 14-Day Assessment was completed on July 19, 2024, which was 24 days after the admission assessment was completed.</p> <p>On June 3, 2025, at 11:04 a.m., clinical nurse supervisor (CNS)-A stated R2's 14-day assessment was completed late. CNS-A stated it</p>	01620		

Minnesota Department of Health

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01620	<p>Continued From page 28</p> <p>was something they had been working hard on to make sure they were completed on time; it was one of the topics at their most recent QAPI (quality assurance and performance improvement) meetings. CNS-A stated they would search R2's record to see if they provided all of their assessments.</p> <p>On June 3, 2025, at 11:36 a.m., CNS-A stated R2's 14-day assessment was completed late. CNS-A stated they had been working hard to follow their plan of correction from their previous survey but somehow the assessment was missed but they did eventually catch the mistake. CNS-A stated all nurses worked together to complete assessments and had a schedule for when assessments were due.</p> <p>The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated, "3. Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services."</p> <p>No additional information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01620		



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Meadow Ridge Senior Living
7475 Country Club Drive
Golden Valley, MN 55427
Hennepin County
Parcel:

Phone:

License Info

License: HFID 31962

Risk:
License:
Expires on:
CFPM: Ivory K. Eastey
CFPM #: 117207; Exp: 12/17/2025

Inspection Info

Report Number: F1021251040
Inspection Type: Full - Single
Date: 6/2/2025 Time: 12:37:36 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery: In Person

! New Order: 3-500B Microbial Control: hot and cold holding

3-501.16A2 *Priority Level: Priority 1 CFP#: 22*

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

COMMENT: COOKED POTATOES (46F) AND WHITE RICE (45F) FOUND IN THE WALK-IN COOLER MEASURED ABOVE 41F. STAFF UNCOVERED THE CONTAINERS AND THEY WILL MONITOR TCS FOOD ITEMS.

Comply By: 6/2/2025 Originally Issued On: 6/2/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.13A *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

COMMENT: ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE IN THE MEMORY CARE 1 (MC1) AND MEMORY CARE 2 (MC2) KITCHENS TO VERIFY THE FINAL UTENSIL SURFACE TEMPERATURE OF THE DISH MACHINES. PROVIDE.

Comply By: 6/9/2025 Originally Issued On: 6/2/2025

New Order: 4-600 Cleaning Equipment and Utensils

4-601.11C *Priority Level: Priority 3 CFP#: 49*

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

COMMENT: THE BOTTOM SECTION OF THE TRUE UPRIGHT COOLER/FREEZER IN THE MC2 KITCHEN CONTAINS DRIED FOOD RESIDUE. CLEAN AND MAINTAIN CLEAN.

Comply By: 6/4/2025 Originally Issued On: 6/2/2025

! New Order: 4-700 Sanitizing Equipment and Utensils

4-702.11 *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

COMMENT: QUAT CONCENTRATION IN THE SINK DISPENSERS OF BOTH MC1 AND MC2 KITCHENS MEASURED 0 PPM. NO SANITIZER CONCENTRATE WAS CONNECTED TO THE DISPENSERS AT THE TIME OF INSPECTION. STAFF PROVIDED A NEW CONTAINER OF SANITIZER CONCENTRATE, AND THE QUAT CONCENTRATION WAS CORRECTED TO 400 PPM DURING THE INSPECTION. CORRECTED ON-SITE.

Comply By: 6/2/2025 Originally Issued On: 6/2/2025

New Order: 6-300 Physical Facility Numbers and Capacities

6-301.14A *Priority Level: Priority 3 CFP#: 10*

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

COMMENT: HANDWASHING SINKS IN BOTH OF THE MC1 AND MC2 KITCHENS ARE MISSING A HANDWASHING SIGN/POSTER THAT REMINDS FOOD EMPLOYEES TO WASH THEIR HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 6/4/2025 Originally Issued On: 6/2/2025

Food & Beverage General Comment

All findings on this report were discussed with Regional Culinary Director, Jeremy Schowreler, Culinary Director, Ivory Eastey and Health Regulation Division Nurse Evaluator, Joey Keen.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1021251040 from 6/2/2025



Ivory Eastery
Culinary Director

Melissa Ramos,
Public Health Sanitarian 3
651-201-4495
melissa.ramos@state.mn.us



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Page: 1

Establishment Info

Meadow Ridge Senior Living
Golden Valley
County/Group: Hennepin County

Inspection Info

Report Number: F1021251040
Inspection Type: Full
Date: 6/2/2025
Time: 12:37:36 PM

Food Temperature: Product/Item/Unit: Cooked Potatoes; **Temperature Process:** Cold-Holding

Location: Walk-in Cooler at 46 Degrees F.

Comment:

Violation Issued?: Yes

Food Temperature: Product/Item/Unit: White Rice ; **Temperature Process:** Cold-Holding

Location: Walk-in Cooler at 45 Degrees F.

Comment:

Violation Issued?: Yes

Food Temperature: Product/Item/Unit: Spaghetti ; **Temperature Process:** Hot-Holding

Location: Hot Wells at 167 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Gravy; **Temperature Process:** Hot-Holding

Location: Hot Wells at 169 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Mac and Cheese; **Temperature Process:** Cold-Holding

Location: Kool-It Upright Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk; **Temperature Process:** Cold-Holding

Location: Walk-in Cooler at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Beef and Barley Soup ; **Temperature Process:** Hot-Holding

Location: Soup Well at 157 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk; **Temperature Process:** Cold-Holding

Location: MC 1 Upright Cooler at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk; **Temperature Process:** Cold-Holding

Location: MC2 Upright Cooler at 34 Degrees F.

Comment:

Violation Issued?: No



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Sanitizer Observations/Recordings

Page: 1

Establishment Info

Meadow Ridge Senior Living
Golden Valley
County/Group: Hennepin County

Inspection Info

Report Number: F1021251040
Inspection Type: Full
Date: 6/2/2025
Time: 12:37:36 PM

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Dispenser

Location: MC1 Sink **Equal To** 0 PPM

Comment:

Violation Issued?: Yes

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Dispenser

Location: MC2 Sink **Equal To** 0 PPM

Comment:

Violation Issued?: Yes

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Dispenser

Location: Three Compartment Sink **Equal To** 400 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Dishwashing Area **Equal To** 165 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Dispenser

Location: MC1 Sink *Corrected **Equal To** 400 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: MC1 **Equal To** 165 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Dispenser

Location: MC2 Sink *Corrected **Equal To** 400 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: MC2 **Equal To** 164 Degrees F.

Comment:

Violation Issued?: No