



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 15, 2025

Licensee

Cardigan Ridge Senior Living
3300 Rice Street
Shoreview, MN 55126

RE: Project Number(s) SL33082016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 17, 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;
- Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
- Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20;

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

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.

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.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Cardigan Ridge Senior Living. **Please contact Renee L. Anderson at 651-201-5871 on or before Thursday September 18, 2025, to schedule the conference call.**

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,



Renee L. Anderson, Supervisor

State Evaluation Team

Email: 651-201-5871

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33082	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/17/2025
NAME OF PROVIDER OR SUPPLIER CARDIGAN RIDGE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3300 RICE STREET SHOREVIEW, MN 55126		
(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: SL #33082016-0</p> <p>On July 14, 2025, through July 17, 2025, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 114 residents, 75 of whom were receiving services under the provider's Assisted Living Facility with Dementia Care license.</p>	0 000	<p>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.</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. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.</p>	
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1) Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may	0 100		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 100	<p>Continued From page 1</p> <p>provide assisted living services until obtaining the required license under paragraphs (c) to (e).</p> <p>(b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.</p> <p>(c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type.</p> <p>(d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.</p> <p>(e) Upon approving an application for an assisted living facility license, the commissioner may:</p> <p>(1) issue a single license for two or more buildings on a campus that are operated by the</p>	0 100		

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0 100	<p>Continued From page 2</p> <p>same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or</p> <p>(2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to manage, control, and/or operate the entire building as an assisted living facility by sharing the building with an office suite in the parking garage on the lower level.</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 licensee's address, 3300 Rice Street, was licensed as an assisted living facility with dementia care (ALFDC).</p> <p>On July 16, 2025, at 1:30 p.m., the surveyor toured the facility with maintenance staff (MS)-J and health unit coordinator (HUC)-L. The facility included a business office suite (suite 100) located below the memory care unit, in a lower-level parking garage. Signage on the door indicated two separate businesses operating from</p>	0 100		

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0 100	<p>Continued From page 3</p> <p>suite 100. The businesses shared an exit stairway with the licensed area. The licensee was unable to provide evidence of proper separation between the facility and the businesses in suite 100.</p> <p>On July 16, 2025, at 1:30 p.m., MS-J and HUC-L acknowledged the findings. HUC-L stated the businesses that were operated out of suite 100 where not a function of the licensed facility and HUC-L did not believe there was an approved building separation between the licensed area and the businesses.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) Days</p>	0 100		
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: Based on observation and interview, the licensee failed to 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</p>	0 775		

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0 775	<p>Continued From page 4</p> <p>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 July 16, 2025, at approximately 11:30 a.m., the surveyor toured the facility with maintenance staff (MS)-J, marketing staff (M)-K and health unit coordinator (HUC)-L. The following was observed:</p> <ol style="list-style-type: none"> 1. The facility is equipped with magnetic locks on the exit doors throughout the memory care wing. At 11:30 a.m. HUC-L confirmed that there was not a switch or button that was able to release the magnetic locking devices from a remote location. 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. 2. The facility was equipped with rated fire doors with tags on the door frame and hinge side of the door, smoke seal, and closers. The fire-resistance rating and smoke-resistant characteristics of smoke barriers shall be maintained. The door smoke seals were missing or damaged in the following locations throughout the facility. <ol style="list-style-type: none"> a. Main, second, and fourth level elevator lobbies. b. Corridor doors outside of unit 220. 3. The facility was equipped with rated fire doors with tags on the door frame and hinge side of the door, smoke seal, and closers. Swinging fire doors shall close from the full-open position and latch automatically. The doors did not close and latch in the following locations. 	0 775		

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0 775	<p>Continued From page 5</p> <p>a. Corridor doors outside of unit 411, 311, 211.</p> <p>b. Corridor door outside of unit 220.</p> <p>c. Second floor community room. The latch was broken and not secured to the door.</p> <p>4. The trash termination room was equipped with rated fire doors with tags on the door frame and hinge side of the door, smoke seal, and closers. Permanent hold opens were present holding the doors open during the tour. Fire doors and smoke and draft control doors shall not be blocked, obstructed, or otherwise made inoperable.</p> <p>5. The trash chute door on the 1st, 2nd, 3rd, and 4th floors did not self-close and positively latch. The door would stay in the open position until assisted to start closing. All trash chute doors should close and latch completely to maintain the fire resistance integrity of the trash chute system that connects all levels of the facility.</p> <p>6. The fire rated door on unit 403 was equipped with a permanent door stop. The resident unit door stayed open with no staff providing patient care or cleaning services.</p> <p>7. The exit door in the north stairway leaving the 2nd level to the 1st level had a door that was not marked with an illuminated exit sign. All exits shall be clearly marked with illuminated exit signage.</p> <p>On July 16, 2025, MS-J, HUC-L and M-K verified the observations while accompanying on the facility tour.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

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0 810	<p>Continued From page 6</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> <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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required training. This had the potential to directly affect all</p>	0 810		

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0 810	<p>Continued From page 7</p> <p>residents, staff, and visitors.</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 July 16, 2025, at approximately 11:30 a.m., the surveyor observed the posted fire evacuation diagrams did not include the identification of the path of egress. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency.</p> <p>On July 16, 2025, marketing staff (M)-K provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p>TRAINING: The licensee failed to provide evacuation training to residents at least once per year. M-K lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.</p> <p>The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. M-K stated that staff training was done upon hire and annually. No other training documentation was provided.</p> <p>On July 16, 2025, at 10:00 a.m., M-K stated they</p>	0 810		

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0 810	<p>Continued From page 8</p> <p>understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 810		
01440 SS=D	<p>144G.62 Subd. 4 Supervision of staff providing delegated nurs</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered</p>	01440		

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01440	<p>Continued From page 9</p> <p>nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of three employees (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> <p>ULP-C was hired April 7, 2022, and provided direct care services for the licensee's residents.</p> <p>On July 14, 2025, from 1:00 p.m., to 1:10 p.m., the surveyor observed ULP-C assisting R7 and R8 with medication administration.</p> <p>ULP-C's record lacked documentation the RN conducted direct supervision of the ULP performing a delegated task within 30 days of performing the task.</p> <p>On July 14, 2025, at 3:45 p.m., licensed assisted living director (LALD)-A stated she would look for ULP-C's 30-day supervision. LALD-A further stated, if it was not in the record "I will be honest, we probably don't have it."</p> <p>On July 15, 2025, at 8:30 a.m., LALD-A stated she was unable to find documentation of the 30-day supervision and she thought it may have been missed during a time when they were having a nursing transition.</p>	01440		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER CARDIGAN RIDGE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 3300 RICE STREET SHOREVIEW, MN 55126		
(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
01440	<p>Continued From page 10</p> <p>The licensee's 6.17 Supervision of Staff - Delegated Services policy, dated February 11, 2022, indicated supervision of unlicensed personnel would be conducted within 30 calendar days after the individual begins working for the licensee and first performs delegated tasks.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01440		
01620 SS=D	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.</p> <p>(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.</p> <p>(c) Resident reassessment and monitoring must be conducted by a registered nurse:</p> <p>(1) no more than 14 calendar days after initiation of services;</p> <p>(2) as needed based on changes in the resident's needs; and</p>	01620		

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01620	<p>Continued From page 11</p> <p>(3) at least every 90 calendar days.</p> <p>(d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment.</p> <p>(e) 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.</p> <p>(f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing resident monitoring and reassessment 14 calendar days from the initiation of services for one of three residents (R3).</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</p>	01620		

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01620	<p>Continued From page 12</p> <p>of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R3 was admitted October 30, 2024.</p> <p>R3's service plan, dated May 16, 2025, indicated R3 received services including assistance with medication administration.</p> <p>On July 15, 2025, at 7:10 a.m., the surveyor observed unlicensed personnel (ULP)-C assisting R3 with medication administration and morning cares.</p> <p>R3's record lacked a resident reassessment, and monitoring conducted no more than 14 calendar days after initiation of services.</p> <p>On July 15, 2025, at 2:20 p.m., clinical nurse supervisor (CNS)-B stated she was unable to locate the 14-day reassessment for R3. CNS-B further stated two of their registered nurses had been gone during that time and the assessment must have been missed.</p> <p>The licensee's 6.01 Assessments, Reviews & Monitoring policy, dated February 11, 2022, indicated the resident reassessment and monitoring would be conducted no more than 14 days after the initiation of assisted living services.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01620		

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01890 01890 SS=D	<p>Continued From page 13</p> <p>144G.71 Subd. 20 Prescription drugs</p> <p>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to date time sensitive medication for one of three residents (R6).</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 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>R6's service plan, dated May 16, 2025, indicated R6 received services including assistance with medication management.</p> <p>R6's medication administration record (MAR), dated July 2025, indicated R6 received 46 units of Lantus (a long-acting insulin used to control blood sugar) daily at 8:00 a.m.</p> <p>On July 15, at 9:20 a.m., the surveyor observed R6's medications with unlicensed personnel (ULP)-F. The medications included a Lantus</p>	01890 01890		

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01890	<p>Continued From page 14</p> <p>insulin injection pen. The pen lacked a date to indicate when the pen was first opened. ULP-F stated she had not been putting opened dates on insulin pens. ULP-F further stated she thought the medications were good through the expiration date listed on the prescription label and she had not been trained to put a date on the pen itself when first opened.</p> <p>On July 15, 2025, at 9:35 a.m., registered nurse (RN)-I stated the ULPs should be putting opened dates on time sensitive medications and "it must just have been missed." RN-I further stated she would provide education to the staff.</p> <p>The manufacturer's prescribing information for the use of Lantus, insulin glargine injection, revised June 2023, indicated the medication should be discarded 28 days after first use.</p> <p>The licensee's 7.13 Medication - Prescription Drugs and Prohibition policy, dated January 14, 2022, indicated prior to being set up for immediate or later administration, prescription drugs would include a beyond-use dated for time sensitive medications.</p> <p>The licensee's 7.36 Medication and Treatments policy indicated staff would check the expiration date on insulin pens.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01890		

Food & Beverage Inspection Report

Page: 1

Establishment Info	License Info	Inspection Info
Cardigan Ridge Senior Living 3300 Rice Street Little Canada, MN 55126 Ramsey County Parcel: Phone:	License: HFID 33082 Risk: License: Expires on: CFPM: FIKRETA OKANOVIC CFPM #: 40353; Exp: 3/2/2026	Report Number: F8058251053 Inspection Type: Full - Single Date: 7/14/2025 Time: 2:39:19 PM Duration: minutes Announced Inspection: <u>Total Priority 1 Orders: 0</u> <u>Total Priority 2 Orders: 0</u> <u>Total Priority 3 Orders: 0</u> Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

HRD INSPECTOR TAMMY CARLSON

167 HAMBURGER - COOK
137 PASTA - HOT WELL
41 TOMATO - PREP

40 GROUND BEEF RAW - WALK IN
40 STRAWBERRY - WALK IN
39 EGG HB - WALK IN

200 PPM QUAT. SANI DISPENSER
162 HOT WATER - DISH MACHINE

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 F8058251053 from 7/14/2025



GRETA OKANOVIC
PIC

Aaron Gertz,
Public Health Sanitarian 3
651-201-4516
aaron.gertz@state.mn.us

Food Establishment Inspection Report

 <p>Metro District Office Minnesota Department of Health 625 Robert St N, PO BOX 64975 St Paul, MN 55164</p>			No. of Risk Factor/Intervention/Violations		0	Date: 7/14/2025	
			No. of Repeat Risk Factor/Intervention/Violations			Time: 2:39:19 PM	
			Score (optional)			Dur: min	
Establishment: Cardigan Ridge Senior Living		Address: 3300 Rice Street		City/State: Little Canada, MN		Zip: 55126	Phone:
License/Permit #: HFID 33082		Permit Holder:		Purpose of Inspection: Full		Est. Type:	Risk Category:

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable

Compliance Status			COS	R
Supervision				
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
Employee Health				
3	IN	knowledge, responsibilities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
Good Hygienic Practices				
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
Preventing Contamination by Hands				
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
Approved Source				
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
Protection From Contamination				
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned, & unsafe food		

GOOD RETAIL PRACTICES

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

Mark "X" or OUT 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

Safe Food and Water			COS	R
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
Food Temperature Control				
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
Food Identification				
37		Food properly labeled; original container		
Prevention of Food Contamination				
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		
Person in Charge (signature)				
Inspector (signature)			Follow-up: No Follow-up Date:	

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

Proper Use of Utensils			COS	R
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
Utensils, 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		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		