Electronically Delivered

December 13, 2022

Administrator
Walker Methodist Highview Hill
20150 Highview Avenue
Lakeville, MN 55044

RE: Project Number(s) SL30735015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 17, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

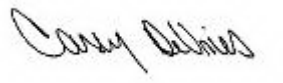
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30735	A. BUILDING: _____ B. WING _____	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HIGHVIEW HILL	20150 HIGHVIEW AVENUE LAKEVILLE, MN 55044

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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30735015-0 On October 14, 2022, through October 17, 2022, the Minnesota Department of Health conducted a survey at the above provider and the following correction orders are issued. At the time of the survey, there were 163 residents, 70 of whom received services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated November 15, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 660	Continued From page 2	0 660		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a 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. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included history and symptoms screening for one of two agency staff (licensed practical nurse (LPN)-Q). 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	0 660		

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0 660	Continued From page 3 situation has occurred only occasionally). The findings include: The licensee's TB risk assessment dated September 19, 2022, indicated the facility was a low risk. LPN-Q began working at the licensee on November 6, 2022, to provide supervision and direct care services. On November 13, 2022, at 3:27 p.m., LPN-Q stated she began working for the facility four days ago and said her duties included providing supervision in the building, assisting direct care staff when needed, following up with any resident situations, such as falls, and following the facility policies. LPN-Q's employee record contained a radiology report of a negative chest x-ray dated July 20, 2018. LPN-Q's employee record lacked evidence of completed TB history and symptoms screen. On November 14, 2022, at 12:58 p.m., licensed assisted living director (LALD)-A stated she suspected for this agency staff [LPN-Q], not having the TB screen "was overlooked." The licensee's Tuberculosis Screening Process Team Members Quality Improvement policy, dated September 10, 2021, indicated all team members will receive TB screening prior to employment or work, and also that volunteers, contractors, students and interns should also be included in the screening process. Screening included: 1. Assessing for current symptoms of active TB infection;	0 660		

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0 660	Continued From page 4 2. Assessing for history of TB; 3. Testing for the presence of Mycobacterium tuberculosis infection. The team member is screened by a licensed nurse utilizing the Baseline TB Screening Tool on day 1 of corporate orientation. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	0 680		

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0 680	Continued From page 5 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide minimum emergency generator system inspections as part of the emergency plan required under Minnesota Rules, Part 4659.0100 to ensure the proper performance of the generator. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 16, 2022, at approximately 2:45 p.m., survey staff received documentation relating	0 680		

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0 680	Continued From page 6 to the emergency generator inspections, maintenance, and load test runs for review from the maintenance director (M)-M. Document review indicated the licensee failed to provide the required minimum frequency of weekly inspection records to meet the requirements for the emergency power generator as outlined under NFPA 110, (referenced under the Code of Federal Regulations, title 42, section 483.73) as part of the facility's emergency plan required under Minnesota Rules, Part 4659.0100, to ensure proper performance of the generator. On November 16, 2022, at approximately 4:30 p.m., the M-M acknowledged the finding that the weekly inspections on the emergency generator were not met. The M-M stated that the requirements appeared to be consistent with nursing home requirements for weekly inspections. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity	0 780		

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0 780	Continued From page 7 of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide working smoke alarms in the resident apartment units 107, 129, 149, 335, 348, 350, and 352. This has the potential to directly affect residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 16, 2022, approximately from 11:10 a.m. to 2:30 p.m., survey staff toured the facility with the maintenance director (M)-M and the licensed assisted living director (LALD-A). During the tour, survey staff observed and the M-M tested and verified the following:	0 780		

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0 780	Continued From page 8 1) The smoke alarms in studio units 129, 149, 335, and 352 failed to sound. 2) The smoke alarm in the hallway of one-bedroom unit 350 was not working properly as it had a low volume. 3) The smoke alarms in the two-bedroom units 107 and 348 failed to sound. On November 16, 2022, at approximately 4:00 p.m., during the exit interview, LALD-A and the M-M acknowledged the above findings. The M-M agreed that they will be going through all the resident living units to verify and replace all smoke alarms as necessary for proper operation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents	0 800		

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0 800	Continued From page 9 and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings are: On November 16, 2022, approximately from 11:10 a.m. to 2:30 p.m., survey staff toured the facility with the maintenance director (M)-M and the licensed assisted living director (LALD-A) During the tour, survey staff observed the following: 1) In apartment unit 350: -The bathroom had a freestanding clothes washer placed across from the vanity inside the bathroom that was not hooked up. The residents explained that they were using it to wash their clothes by running the hose and discharging the indirect waste piping from the washer into the lavatory bowl and connecting the water hook-up to the lavatory faucet supply fitting. The residents added that they did not want to use the community laundry room due to concerns about sanitation and would like to have their own washer and dryer, and did not want to move to another room where those items were provided for use. Survey staff explained to the LALD-A and the M-M that a lavatory must not be used to serve a clothes washer indirect waste and water supply. A clothes washer is a plumbing fixture and must be provided with an approved	0 800		

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0 800	Continued From page 10 dedicated waste receptor (such as a standpipe or similar) and an approved permanent hot and cold water supply. The improper installation and misuse of a plumbing fixture pose potential overflowing from the clothes washer and indirect waste piping onto the floor creating slippery conditions and the potential impact on the structural damage of the building if an overflow situation did happen. In addition, the hookup to the lavatory sink also poses concerns about contamination of the water supply through the cross-connection of the lavatory faucet. -The bedroom had an electric clothes dryer sitting next to the window (unplugged) with a dryer exhaust vent pipe installed through the window opening. Survey staff again explained that the dryer installation must not be located inside a bedroom. The installation poses concern about the window opening during the winter months allowing cold air to enter the bedroom and the temperature in the room could not be regulated. 2) FIRE-RATED DOORS - The corridor fire-rated doors for the 3rd-floor trash room, the building the mechanical room across from resident unit 108, and the storage room on the second floor across from the health services room had self-closing arm hardware removed preventing doors from self-close to protect and maintain the smoke-tight integrity of the building corridors. -The fire-rated doors to the resident storage room on the main floor, the elevator lobby connecting to the lower-level parking garage next to the maintenance room, and the storage room on the 2nd floor across from AW Merchant failed to be positively latched when closed. -The corridor fire-rated doors to the 2nd-floor	0 800		

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0 800	Continued From page 11 library and common areas, and the 3rd-floor laundry room were kept open using door wedges/stops. Survey staff explained to the M-M that all fire-rated doors must be in proper working order to maintain the integrity of the fire safety plan and must be able to close to protect against the spread of smoke and flames to compartmentalize the building to protect the residents, staff, and visitors. The M-M verified the above findings. 3) An extension cord was used in the 2nd-floor storage room across from the health services room serving a window air conditioning unit that posed a potential electrical fire hazard from overloading the electrical circuits. The M-M agreed with the finding. 4) The installation of the chemical soap dispenser connected to the faucet of the mop sink located in the maintenance area was not protected with the proper pressure bleeding device, creating a risk of backflow of chemicals into the potable water supply. On November 16, 2022, at approximately 4:00 p.m., during the exit interview, LALD-A and the M-M acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 12 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on documentation review and interview, the licensee failed to provide the minimum required number of employee evacuation drills. This has the potential to directly affect the safety of residents receiving care, staff, and visitors.	0 810		

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0 810	Continued From page 13 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 16, 2022, at approximately 2:45 p.m. survey staff reviewed the facility's fire safety and evacuation plan and related documentation. The review of the documentation indicated the licensee failed to show compliance with the minimum number of required employee fire and evacuation drills for their three-shift day work schedule of two drills per year per shift with at least one drill every other month. Drill records provided for the review were dated, 8/30/2022 (3:00 p.m.), 7/5/2022 (1:35 p.m.), 4/29/2022 (13:05), 3/31/22 (6:20 a.m.), 2/28/22 (16:00), 1/31/2022 (13:00), 12/2/2021 (9:00 a.m.), and 7/8/2021 (no time). On November 16, 2022, at approximately 4:00 p.m., during the exit interview, the licensed assisted living director-A and the environmental director-M acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required	0 900		

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0 900	Continued From page 14 (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 900		

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0 900	Continued From page 15 licensee failed to develop and execute a written assisted living contract with the required content for one of six residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The finding include: The licensee failed to give a completed copy of the signed contract to R5 promptly after the contract was signed. R5 was admitted to the facility August 30, 2022, with diagnoses including metabolic encephalopathy and frequent falls. R5's record included a Resident Agreement Summary of Important Terms document, dated and signed by R5 August 29, 2022. The document included a section to be signed and dated by the licensee's representative, but it was blank, unsigned, and undated. On November 16, 2022, the licensed assisted living director (LALD)-A said the document was the contract between R5 and licensee and said the licensee section had not been signed and dated to complete the contract as required. LALD-A further stated all resident contracts are considered complete and binding when both the licensee and resident or resident representative have signed it.	0 900		

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0 900	Continued From page 16 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01060 SS=E	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case	01060		

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01060	Continued From page 17 manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based interview and record review, the licensee failed to ensure a notice with required content was provided to the resident/representative for two of three residents (R2, R5) who had an emergency relocation out of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted for assisted living with dementia care services on July 5, 2022. R2's Service Plan Agreement, dated August 4, 2022, indicated R2 received medication management, assistance with bathing, dressing and grooming, escorts to and from dining, safety checks, housekeeping, and laundry services.	01060		

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01060	Continued From page 18 A nursing progress note dated November 11, 2022, indicated that following a fall July 19, 2022, R2 was transferred to a transitional care unit and returned to the facility on August 4, 2022. The progress note indicated R2 was also hospitalized from August 9, 2022, to August 15, 2022, and returned to the facility. Although R2 was relocated from the facility for 16 days (July 19 through August 4) and for 6 days (August 9 through August 15), R2's record lacked evidence the licensee provided the resident or representative written emergency relocation notices as required. On November 17, 2022, at 1:58 p.m., licensed assisted living director (LALD)-A said R2 had two relocations from the facility. LALD-A was unable to locate any notice given to R2. R5 R5's Service Plan Agreement dated September 9, 2022, indicated R5 received medication management, assistance with bathing, dressing and grooming, escort to meal, TED (compression) stocking assistance, nail care, bed linen change, daily apartment tidy, and laundry. R5's Progress Note dated September 24, 2022, at 11:46 p.m., indicated, "writer notified by a.m. nurse that client [resident] was transferred to hospital with abdominal pain. Writer followed up and client admitted to FVR [abbreviation of name of hospital] with bowel impaction." R5's Progress Note dated September 27, 2022, at 6:21 p.m., indicated resident returned to licensee after hospitalization for abdominal pain due to bowel impaction. Even though R5 relocated from the facility from	01060		

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01060	Continued From page 19 September 24, 2022, to September 27, 2022, for three days, R5's record lacked evidence the licensee provided the resident or representative a written emergency relocation notice. R2 and R5's records lacked evidence a written emergency relocation notice was provided to the resident and resident's representative that at minimum contained: - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. On November 17, 2022, at 2:50 p.m., LALD-A said R5 was admitted to hospital, but licensee did not complete a written emergency relocation notice. LALD-A said in both instances, the ombudsman was not notified. LALD-A stated they were working on system changes to better improve communication and capture resident records. The licensee's Emergency Relocation policy, revised September 3, 2021, indicated the licensee will provide residents assisted living services and housing in accordance with state law and adhere to applicable rules, statues, and resident rights in issues related to the most	01060		

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01060	Continued From page 20 appropriate placement and temporary transfer outside the community. The policy indicated the facility may remove a resident from the facility in the event of an emergency, if necessary, due to urgent medical needs and that an emergency relocation is not a termination. The policy indicated the facility will provide written notice as soon as practicable to the resident, resident's representative, designated representative, office of Ombudsman and (if applicable) case manager and the notice would include the items listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01350 SS=F	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure orientation to assisted living licensing and requirements was completed for all employees prior to providing services for two of two agency staff reviewed, (unlicensed personnel (ULP)-D and licensed practical nurse (LPN)-Q). 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	01350		

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01350	Continued From page 21 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-D and LPN-Q's employee records lacked orientation to assisted living to include: - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -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 -a review of the types of assisted living services the employee will be providing and the facility's category of license. ULP-D ULP-D began providing assisted living services for the licensee on November 14, 2022. On November 14, 2022, at 3:59 p.m., the surveyor observed ULP-D assist R2 with toileting in the resident's room. ULP-D's employee record included an Emergency Staffing Orientation Checklist, dated November 14, 2022, which indicated the employee had orientation to the facility completed	01350		

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01350	Continued From page 22 by director of health services/registered nurse (DHS/RN)-B. Topics on the checklist included communication, environment, resident care/equipment, culinary and infection control. The orientation lacked required content listed above. LPN-Q LPN-Q began providing assisted living services for the licensee on November 6, 2022. On November 13, 2022, at 3:27 p.m., LPN-Q stated she began working for the facility four days ago and said her duties included providing supervision in the building, assist direct care staff when needed, follow up with any resident situations, such as falls, and follow the facility policies. LPN-Q's employee record included an Emergency Staffing Orientation Checklist, dated November 6, 2022, which indicated the employee had an orientation to the facility, completed by director of health services/registered nurse (DHS/RN)-B. Topics on the checklist included communication, environment, resident care/equipment, culinary and infection control. The orientation lacked required content listed above. On November 17, 2022, at 12:58 p.m., licensed assisted living director (LALD)-A said when they use agency staff, those persons are provided an orientation to the facility and they use a checklist, which LALD-A felt included the required content. LALD-A said they may have to review the orientation content provided for new agency staff. LALD-A also said all agency would have the same orientation.	01350		

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01350	Continued From page 23 The licensee's New Hire/Re-Hire Orientation policy, dated June 24, 2022, indicated all new hires and rehires will attend orientation at the start of their employment. The policy indicated orientation included the topics identified above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01350		
01470 SS=D	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 complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of	01470		

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01470	Continued From page 24 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 (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (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: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure orientation to assisted living licensing and requirements included all required content for one of four employees, (unlicensed personnel (ULP)-O). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01470		

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01470	Continued From page 25 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). ULP-O started employment January 3, 2017, under the comprehensive license and started providing assisted living services August 1, 2021. On November 16, 2022, at 9:35 a.m., the surveyor observed ULP-O complete a blood sugar check and administer medications to R9. ULP-O's employee record lacked required orientation to assisted living regulations completed prior to providing services to residents to include: - Overview of Assisted Living statutes; - Review of provider's policies and procedures; - Assisted Living bill of rights; - Handing of resident complaints, reporting of complaints, where to report; - Consumer advocacy services; - Review of types of Assisted Living services the employee will provide and provider ' s scope of license; and - Principles of person-centered planning/service delivery. On November 17, 2022, at 11:40 a.m., licensed assisted living director (LALD)-A said ULP-O's employee record lacked orientation to assisted living licensing requirements and regulations. LALD-A stated ULP-O had completed orientation in the licensee's corporate office but was not sure how the training record was missing from the file. Licensee's undated New Hire/Re-Hire Orientation	01470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30735	A. BUILDING: _____ B. WING _____	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST HIGHVIEW HILL	20150 HIGHVIEW AVENUE LAKEVILLE, MN 55044

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01470	Continued From page 26 Quality Improvement policy indicated all new hires will attend orientation at the start of their employment. No further information provided TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01890 SS=D	144G.71 Subd. 20 Prescription drugs 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a time-sensitive medication was dated when opened and a chemo-therapy drug was appropriately labeled for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 was admitted to licensee July 21, 2022, with	01890		

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01890	Continued From page 27 diagnoses to include cerebral infarction, neuropathy, and unspecified encephalopathy. R4's Service Plan Agreement dated November 8, 2022, indicated R4 received licensed nursing services, complex medication administration, and medication review services. On November 15, 2022, at 8:35 a.m., the surveyor reviewed a medication cart on the care suites unit and observed in R4's box the following medication: Xtandi (enzalutamide capsules) 40 milligram (mg) in the manufacturer's bottle. The medication did not have a pharmacy label with dispensing instructions. On November 17, 2022, at 8:45 a.m., surveyor observed ULP-P prepare and administer Lantus Solostar insulin via insulin pen injection to R4. After the administration, the surveyor noted neither R4's insulin pen nor the original box it came in was dated when opened. On November 17, 2022, at 9:10 a.m., ULP-P stated all insulin is to be labeled with open date when it is first brought into the cart before starting to use it. On November 17, 2022, at 11:20 a.m., registered nurse (RN)-E said R4's time-sensitive medication was not dated and stated all time sensitive medications were to be labeled with an opened date, and all ULPs know that. As to why R4's Xtandi medication had no label, RN-E stated it may be the label fell off, was not sure how that happened but it should be labeled. The licensee's Medication Management Services policy, dated September 29, 2022, indicated over the counter medications and dietary supplements	01890		

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	30735	A. BUILDING: _____ B. WING _____	11/17/2022

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WALKER METHODIST HIGHVIEW HILL	20150 HIGHVIEW AVENUE LAKEVILLE, MN 55044

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01890	Continued From page 28 must maintain proper prescription labeling as is a standard with prescription drugs. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02240 SS=D	144G.90 Subdivision 1 Assisted living bill of rights; notification (a) An assisted living facility must provide the resident a written notice of the rights under section 144G.91 before the initiation of services to that resident. The facility shall make all reasonable efforts to provide notice of the rights to the resident in a language the resident can understand. (b) In addition to the text of the assisted living bill of rights in section 144G.91, the notice shall also contain the following statement describing how to file a complaint or report suspected abuse: "If you want to report suspected abuse, neglect, or financial exploitation, you may contact the Minnesota Adult Abuse Reporting Center (MAARC). If you have a complaint about the facility or person providing your services, you may contact the Office of Health Facility Complaints, Minnesota Department of Health. You may also contact the Office of Ombudsman for Long-Term Care or the Office of Ombudsman for Mental Health and Developmental Disabilities." (c) The statement must include contact information for the Minnesota Adult Abuse Reporting Center and the telephone number, website address, e-mail address, mailing address, and street address of the Office of Health Facility Complaints at the Minnesota Department of Health, the Office of Ombudsman	02240		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02240	Continued From page 29 for Long-Term Care, and the Office of Ombudsman for Mental Health and Developmental Disabilities. The statement must include the facility's name, address, e-mail, telephone number, and name or title of the person at the facility to whom problems or complaints may be directed. It must also include a statement that the facility will not retaliate because of a complaint. (d) A facility must obtain written acknowledgment from the resident of the resident's receipt of the assisted living bill of rights or shall document why an acknowledgment cannot be obtained. Acknowledgment of receipt shall be retained in the resident's record. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current Minnesota Bill of Rights for Assisted Living Residents was provided to two of six residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R4 R4 was admitted to licensee July 21, 2022, with diagnoses to include cerebral infarction, neuropathy, and unspecified encephalopathy. R4's Service Plan Agreement dated November 8, 2022, indicated R4 was receiving licensed nurse	02240		

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WALKER METHODIST HIGHVIEW HILL	20150 HIGHVIEW AVENUE LAKEVILLE, MN 55044

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02240	Continued From page 30 services, complex medication administration, and medication review. R4's Resident Agreement dated July 19, 2022, included the Minnesota Bill of Rights for Assisted Living Residents version dated May 16, 2021. The record lacked evidence R4 was provided the most current version of Minnesota Bill of Rights for Assisted Living Residents. R5 R5 was admitted to licensee August 30, 2022, with diagnoses to include metabolic encephalopathy, and frequent falls. R5's Service Plan Agreement dated September 9, 2022, indicated R4 was receiving bathing services, escort for meals, dressing, TED stocking assist, complex medication administration, and medication review. R5's Resident Agreement dated August 29, 2022, included the Minnesota Bill of Rights for Assisted Living Residents version dated May 16, 2021. The record lacked evidence R5 was provided the most current version of Minnesota Bill of Rights for Assisted Living Residents. On November 17, 2022, at 2:20 p.m., licensed assisted living director (LALD)-A said R4 and R5'S record lacked the most current Minnesota Bill of Rights for Assisted Living Residents version dated November 8, 2022. LALD-A stated they sent out the current version to all residents and had started receiving back acknowledgments. LALD-A also stated licensee kept track of residents who returned the signature page but was not sure how they had left out R4 and R5 in their mail out list. No further information was provided	02240		

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02240	Continued From page 31 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02240		

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

Type: Full
Date: *11/15/22*
Time: 12:53:14
Report: 1004221297

Food and Beverage Establishment Inspection Report

Location:
Walker Methodist Highview Hill
20150 Highview Avenue
Lakeville, MN55044
Dakota County, 19

Establishment Info:
ID #: 0038344
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529859000
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

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

3-304.14B

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

WIPING CLOTHS FOUND STORED IN A SOAPY WATER SOLUTION. DISCONTINUE STORING WIPING CLOTHS IN SOAPY WATER. WIPING CLOTHS MUST BE STORED IN AN APPROVED SANITIZING SOLUTION TO PREVENT BACTERIAL GROWTH. *CORRECTED ON SITE.

Corrected on Site

4-400 Equipment Location and Installation

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

DISH LINE (CLEAN AND DIRTY SIDE) IS NO LONGER SEALED TO THE WALL. RESEAL TO PREVENT BACKSPLASH AND DEBRIS FROM ACCUMULATING BETWEEN EQUIPMENT AND WALL SPACE.

Comply By: 11/29/22

4-600 Cleaning Equipment and Utensils

4-602.11D5

MN Rule 4626.0845D5 Clean equipment used for the storage of packaged or unpackaged food, such as a reach-in refrigerator, at a frequency which precludes accumulation of soil residues.

INNER PORTION OF THE 2-DOOR FREEZER FOUND WITH AN ACCUMULATION OF FOOD DEBRIS. CLEAN THOROUGHLY AND MAINTAIN CLEAN. DIRECTOR STATED IT WOULD BE CLEANED TODAY.

Comply By: 11/15/22

Surface and Equipment Sanitizers

Wash Temp. Gauge: = at 168 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Rinse Temp. Gauge: = at 180 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Utensil Surface Temp.: = at 168 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: FISH
Temperature: 168 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Process/Item: RICE
Temperature: 157 Degrees Fahrenheit - Location: STEAM WELL
Violation Issued: No

Process/Item: HASHBROWNS
Temperature: 41 Degrees Fahrenheit - Location: PULL-OUT DRAWER COOLER
Violation Issued: No

Process/Item: BATTER
Temperature: 39 Degrees Fahrenheit - Location: PULL-OUT DRAWER COOLER
Violation Issued: No

Process/Item: TURKEY
Temperature: 41 Degrees Fahrenheit - Location: PREP TOP COOLER
Violation Issued: No

Process/Item: TUNA
Temperature: 40 Degrees Fahrenheit - Location: PREP TOP COOLER
Violation Issued: No

Process/Item: SLICED TOMATO
Temperature: 41 Degrees Fahrenheit - Location: REACH-IN PREP COOLER
Violation Issued: No

Process/Item: BEANS
Temperature: 41 Degrees Fahrenheit - Location: 2-DOOR TRUE REFRIGERATOR
Violation Issued: No

Process/Item: TOMATO SAUCE
Temperature: 41 Degrees Fahrenheit - Location: 2-DOOR TRUE REFRIGERATOR
Violation Issued: No

Process/Item: CUT MELON
Temperature: 36 Degrees Fahrenheit - Location: HOSHIZAKI COOLER
Violation Issued: No

Process/Item: SOUP
Temperature: 201 Degrees Fahrenheit - Location: SOUP WELL
Violation Issued: No

Process/Item: SOUP
Temperature: 175 Degrees Fahrenheit - Location: SOUP WELL
Violation Issued: No

Process/Item: FRUIT
Temperature: 36 Degrees Fahrenheit - Location: REACH-IN TRUE REFRIGERATOR
Violation Issued: No

Process/Item: PORK
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: CHEESE
Temperature: 38 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: RICE
Temperature: 156 Degrees Fahrenheit - Location: METRO HOT HOLDING CABINET
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY BRUCE MELCHERT.

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-DATE MARKING PROCEDURES
-COOLING PROCEDURES
-REHEATING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES
-FOOD SOURCE
-RECEIVING DELIVERIES PROCEDURES
-FOOD SERVICE PROCEDURES
-PEST CONTROL

-LOGS (COOLER TEMPERATURE, COOLING TEMPERATURES, SANITIZER CONCENTRATIONS, ETC)
-PHYSICAL FACILITIES AND MAINTENANCE
-ALL VIOLATIONS ON THIS REPORT

*IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE RESIDENT, OR CALL ON THEIR BEHALF. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

**REPORT WAS DISCUSSED WITH THE DIRECTOR OF CULINARY SERVICES, AMBER, THE EXECUTIVE DIRECTOR, CATHERINE, AND WITH THE NURSE EVALUATOR, BRUCE.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1004221297 of 11/15/22.

Certified Food Protection Manager: AMBER BLAKER

Certification Number: FM33519 Expires: 08/25/24

Signed: _____

AMBER BLAKER
DIR. OF CULINARY SERVICES

Signed: Molly Dougherty

Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us