Electronically Delivered

November 10, 2025

Licensee
Orchards of Minnetonka
10955 Wayzata Boulevard
Minnetonka, MN 55305

RE: Project Number(s) SL34716016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 29, 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 . . ."

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34716	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARDS OF MINNETONKA	10955 WAYZATA BOULEVARD MINNETONKA, MN 55305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34716016-0 On October 27, 2025, through October 29, 2025, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 163 residents; 76 residents receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program	0 510		

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0 510	Continued From page 1 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical, and nursing standards for infection control related to gloving for two of six employees (unlicensed personnel (ULP)-J, ULP-K). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-J On October 28, 2025, at 6:21 a.m. through 6:59 a.m., the surveyor observed ULP-J with gloves	0 510		

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0 510	Continued From page 2 on assisting R2 in the resident's bathroom. ULP-J partially applied a pull-up brief, pants, and shoes to R2 then removed gloves and exited the bathroom to provide R2 with privacy. Without performing hand hygiene, ULP-J reached into their pocket, grabbed a new pair of gloves, applied the new pair of gloves, placed a gait belt on R2, assisted R2 to a standing position, and cleaned R2's perineal area. With out glove removal or performing hand hygiene, ULP-J raised R2's pull-up brief and pants, adjusted R2's shirt, moved the wheelchair closer to the toilet, assisted R2 to sit in the wheelchair, removed gait belt, and removed gloves. Without performing hand hygiene, ULP-J moved R2 to the bathroom sink, set up oral care and shaving supplies, grabbed a new pair of gloves from their pocket, applied the new pair of gloves, assisted R2 with face washing and hand washing, removed one glove, cleaned up the sink area, and removed the other glove. Without performing hand hygiene, ULP-J emptied the trash, assisted R2 to put on hat and glasses, exited R2's room, assisted R2 with walker and wheelchair to walk the entire length of the unit and back, brought R2 to the common dining room sink, R2 and ULP-J then washed their hands. On October 28, 2025, at 7:00 a.m., ULP-J stated they were trained to wash hands when gloves were removed and to wash hands after providing cares. The surveyor inquired why ULP-J did not perform hand hygiene after glove removal when working with R2. ULP-J stated, "sometimes when it is not physically soiled you can put the gloves on but at the end of the care you must wash your hands." ULP-K	0 510		

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0 510	Continued From page 3 On October 28, 2025, at 7:53 a.m., the surveyor observed ULP-K remove and apply gloves from their pocket and raise R9's pull-up brief and pants. R9 self-transferred to the wheelchair. ULP-K moved R9's wheelchair to the bathroom sink, assisted R9 with grooming, and removed their gloves. Without performing hand hygiene, ULP-K removed the trash bag from the trash can, brushed R9's hair, applied hearing aids and glasses to R9, retrieved a long sleeve shirt and sweater from the closet, assisted R9 with application of the shirts, brought R9 to the dining room, dropped of trash, and sanitized hands. On October 28, 2025, at 8:13 a.m., ULP-K stated they were trained to change gloves if gloves were soiled or if they moved from a dirty task to a clean task. ULP-K stated they were trained to wash their hands after glove removal. The surveyor inquired why they did not perform hand hygiene after glove removal. ULP-K stated they were moving fast because they feared R9 would fall from impulsive behaviors like self-transferring and "I made a mistake I should have washed them". In addition, ULP-K stated there was a lack sanitizer in the secured unit. ULP-K stated they were only able to get sanitizer at the trash room and at the medication cart, and they believed the licensee's staff needed more access to sanitizer. On October 29, 2025, at 9:35 a.m., during an interview with clinical nurse supervisor (CNS)-C and regional clinical director (RCD)-E, CNS-C stated employees were trained on infection control during corporate orientation and inhouse orientation. CNS-C stated the licensee trained staff on handwashing by using glow germ (a solution used to help teach proper handwashing techniques). CNS-C stated ULP were trained on	0 510		

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0 510	Continued From page 4 personal protective equipment (PPE) and were trained to wash or sanitize hands after glove removal unless there was a safety issue with the resident. RCD-E stated many sanitizing stations were removed from the secured unit due to the resident's diagnoses however, staff were provided with pocket sanitizer. RCD-E stated each task a ULP performs has a procedure built into the instructions that will walk them step by step on how to perform the task. RCD-E stated ULP were trained to wash their hands, apply gloves, remove gloves, and wash hands. The Centers for Disease Control (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers dated February 27, 2024, recommended to clean your hands: - immediately before touching a patient; - before performing an aseptic task such as placing and indwelling device or handling invasive medical devices; - before moving from work on a soiled body site to a clean body site on the same patient; - after touching a patient or patient's surroundings; - after contact with blood, body fluids, or contaminated surfaces; and - immediately after glove removal. The licensee's 8.07 Gloves policy dated August 1, 2021, indicated after gloves were disposed of, rewash hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 5 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include a signature or other authentication by the facility and by the resident and/or resident representative documenting an agreement on treatment services that would be provided for one of five residents (R2). 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	01640		

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01640	Continued From page 6 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted to the licensee on October 30, 2024, and began receiving assisted living services. R2's diagnoses included parkinsonism, coronary artery disease, dementia, psychotic disturbance of mood, anxiety, and left knee osteoarthritis. On October 28, 2025, at 6:21 a.m., the surveyor observed unlicensed personnel (ULP)-J apply compression stockings to R2's bilateral (both) legs. R2's Service Contract (Private) signed September 22, 2025, indicated R2 received assistance with ambulation, bathing, bed mobility, dressing, eating, escorts, grooming, laundry, medication administration, oral care, vital sign monitoring, toileting, transfers, and safety checks. R2's unsigned Service Contract (Waiver) dated October 28, 2025, indicated R2 received assistance with ambulation, bathing, bed mobility, compression stockings, dressing, eating, escorts, grooming, laundry, medication administration, oral care, vital sign monitoring, toileting, transfers. The unsigned service plan indicated a new service of compression stockings was added. R2's Resident Notes-One Resident dated April	01640		

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01640	Continued From page 7 28, 2025, through October 28, 2025, indicated on October 22, 2025, a new order was received for compression stocking 15-20 mmhg on bilateral lower extremities to be put on during the day and off at the night. In addition, R2's compression stocking measurements were sent to the pharmacy and services for compression stockings would initiate once the facility received the compression stockings. The progress notes did not indicate the resident and/or designated representative was updated or agreed to the added service. R2's providers orders signed October 21, 2025, included compression stockings 15-20 millimeters of mercury (mmhg) on bilateral lower extremities to be put on during the day and off at night. R2's Service Recap Summary- Month dated October 2025 indicated R2 received assistance with compression stockings twice per day and R2 received assistance with compression stockings on October 24, 25, 26, 27, and 28, 2025. On October 29, 2025, at 9:20 a.m., during interview with regional clinical director (RCD)-E, and clinical nurse supervisor (CNS)-C, RCD-E stated residents did not sign a new service plan if it did not affect the amount of money they paid for services. RCD-E stated the licensee's staff members would update the family and update the provider on a new service. RCD-E stated they did not have a signed service plan that indicated R2 received compression therapy. RCD-E stated they provided a copy of the planned services for R2 to review but it did not require a signature. RCD-E stated in January 2026 the licensee will move to a different service plan system then what	01640		

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01640	Continued From page 8 was provided to them at the change of ownership, and the new system would trigger staff members to obtain a signature for each change of service. RCD-E stated the policy that was provided to the surveyor related to service plans, would be how the new ownership operates however, there is currently a "gap" between how the previous owners completed service plans due to the point system. CNS-C stated their practice was if a service was added to the service plan, the service plan would only be signed if there was a price increase to the resident. The licensee's 6.08 Service Plan policy dated August 1, 2022, indicated the service plan and any revisions shall include a signature or other authentication by the licensee and by the resident, or resident representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store all medications in a securely locked location for five of five residents (R4, R5, R6, R7, R8) who	01880		

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01880	Continued From page 9 resided in licensee's non-memory care assisted living area. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 28, 2025, at 6:40 a.m., during continuous observation of a medication administration in each resident's apartment, R4, R5, R6, R7, and R8's apartments included unsecured over the counter (OTC) or supplement medications accessible by each resident. R4 R4's apartment included an unsecured bottle of Total Beets supplements, bottle of Super Beets supplements, bottle of OTC ear wax removal drops, OTC gas relief box of pills, and OTC fluticasone propionate nasal spray bottle on R4's counters. R4 was admitted on January 6, 2025. R4's Service Plan (Private) - Addendum to Contract dated February 4, 2025, indicated R4 received the service of Medication Administration, and OTC medications and supplements would be managed by the licensee. R4's Assessment dated October 24, 2025,	01880		

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01880	Continued From page 10 indicated under the Medications section for secure storage of all other medications, that medications were secured in a locked medication cart and medications were accessible to med (medication) passer and nursing only. R5 R5's apartment was a double occupancy apartment R5 shared with their spouse. On the kitchen counter was a full Medi-Minder (a plastic organizer with compartments for the days of the week which included R5's spouse's weekly medications) which was unsecured and accessible by R5. R5 was admitted on December 27, 2023. R5's Service Plan (Private) dated July 25, 2025, indicated R5 received the service of Medication Administration, and OTC medications and supplements would be managed by the licensee. R5's Assessment dated October 20, 2025, indicated under the Medications section for secure storage of all other medications, that medications were secured in a locked medication cart and medications were accessible to med passer and nursing only. R6 R6's apartment included an unsecured kitchen cabinet where the following medications were stored and accessible by R6: Excedrin (OTC used for headache management); Tylenol Extra Strength (OTC used for management of pain); Meta Mucil (OTC used to digestion and constipation prevention); Vitamin Code D3 (Vitamin D supplement); Cultural Probiotic (OTC used for digestion support); Clearlax (OTC used	01880		

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01880	Continued From page 11 to treat constipation); and Kaopectate (OTC used for diarrhea and upset stomach). R6 was admitted on February 22, 2024. R6's Service Plan (Private) dated October 23, 2025, indicated R6 received the service of Medication Administration, and OTC medications and supplements would be managed by the licensee. R6's Assessment dated October 23, 2025, indicated under the Medications section for secure storage of all other medications, that medications were secured in a locked medication cart and medications were accessible to med passer and nursing only. R7 R7's apartment included an unsecured bottle of an OTC one daily women's multivitamin supplement. R7 was admitted on November 5, 2023. R7's Service Plan (Private) dated July 20, 2025, indicated R7 received the service of Medication Administration, and OTC medications and supplements would be managed by the licensee. R7's Assessment dated October 16, 2025, indicated under the Medications section for secure storage of all other medications, that medications were secured in a locked medication cart and medications were accessible to med passer and nursing only. R8 R8's apartment included an unsecured bottle of	01880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 12 Systane eye drops (OTC eye drop for lubrication of the eye). R8 was admitted on May 30, 2019. R8's Service Plan (Private) dated July 7, 2025, indicated R8 received the service of Medication Administration, and OTC medications and supplements would be managed by the licensee. R8's Assessment dated September 19, 2025, indicated under the Medications section for secure storage of all other medications, that medications were secured in a locked medication cart and medications were accessible to med passer and nursing only. On October 29, 2025, at 9:30 a.m., clinical nurse supervisor (CNS)-C and regional clinical director (RCD)-E stated the identified medications should not be unsecured in each resident's respective apartments. RCD-E stated residents and resident's families sometimes ordered medication through delivery services without the licensee's knowledge. CNS-C stated unlicensed personnel (ULP) were all trained to notify the nurse when medications were noted in rooms where the licensee provided medication management. RCD-E stated licensee would need to implement a new procedure to manage OTC medications and how to best ensure each resident receives the services to safely administer medications. The licensee's 7.11 Medication Storage policy dated August 1, 2021, indicated medications would be stored consistent with each resident's medication management plan and service plan. No further information was provided.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34716	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ORCHARDS OF MINNETONKA	10955 WAYZATA BOULEVARD MINNETONKA, MN 55305

(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
01880	Continued From page 13 TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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

Food & Beverage Inspection Report

Establishment Info

ORCHARDS OF MINNETONKA
10955 WAYZATA BOULEVARD
Minnetonka, MN 55305
Hennepin County
Parcel:

Phone:

License Info

License: HFID 34716

Risk:
License:
Expires on:
CFPM: Betsy McCormick
CFPM #: 105475; Exp: 3/15/2027

Inspection Info

Report Number: F7963251066
Inspection Type: Full - Single
Date: 10/28/2025 Time: 10:49:29 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

MET WITH HRD NURSE SURVEYOR ASHLEY CREWS AND ESTABLISHMENT REPRESENTATIVES BETSY MCCORMICK, STEVE CAMERON AND TOM FRETTE. DISCUSSED THE FOLLOWING-

-EMPLOYEE ILLNESS POLICY AND LOG
-REPORTABLE DISEASES
-SUSCEPTIBLE POPULATION RESTRICTIONS
-COOLING
-COLD HOLDING ON ICE
-LAYOUT OF BUILDING

THIS IS A BUILDING THAT HOLDS POPULATION FOR INDEPENDENT LIVING, ASSISTED LIVING AND MEMORY CARE. A SPA POOL IS ON SITE THAT IS LICENSED AND INSPECTED BY THE CITY OF MINNETONKA. THERE IS A MAIN COMMERCIAL KITCHEN WITH CONNECTED DINING ROOMS FOR BOTH ASSISTED LIVING AND MEMORY CARE. A SEPARATE CAFE IS ON SITE ALSO.

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 F7963251066 from 10/28/2025

Betsy McCormick
Culinary Director

Peggy Spadafore,
Public Health Sanitarian Supervisor
651-201-3979
peggy.spadafore@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

ORCHARDS OF MINNETONKA
Minnetonka
County/Group: Hennepin County

Inspection Info

Report Number: F7963251066
Inspection Type: Full
Date: 10/28/2025
Time: 10:49:29 AM

Food Temperature: Product/Item/Unit: SL TOMATOES**; Temperature Process:**
Location: PREP COOLER at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHICKEN SALAD**; Temperature Process:**
Location: PREP COOLER at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: TOMATO SOUP**; Temperature Process:**
Location: Hot Holding at 190 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: milk**; Temperature Process:**
Location: BEV AREA at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SOUP**; Temperature Process:**
Location: Hot Holding at 191 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CKD CHICKEN**; Temperature Process:**
Location: WALKIN at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SPINACH DIP**; Temperature Process:**
Location: WALKIN at 34 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SOUP**; Temperature Process:** COOLING
Location: WALKIN at 63 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT MELON**; Temperature Process:**
Location: SALAD COOLER at 39 Degrees F.
Comment:
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

ORCHARDS OF MINNETONKA
Minnetonka
County/Group: Hennepin County

Inspection Info

Report Number: F7963251066
Inspection Type: Full
Date: 10/28/2025
Time: 10:49:29 AM

Sanitizing Chemical: Product: Quaternary Ammonia**; Sanitizing Process:**
Location: SANI DISPENSER **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia**; Sanitizing Process:**
Location: SANI BUCKET **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: Product: Hot Water**; Sanitizing Process:**
Location: DISHWASHER RINSE **Equal To** 168 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F7963251066

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	0	Date: 10/28/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:49:29 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
ORCHARDS OF MINNETONKA	10955 WAYZATA BOULEVARD	Minnetonka, MN	55305	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 34716		Full		

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

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	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, responsibiities, 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		

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

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

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

			COS	R
	Safe Food and Water			
30	N/A	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	IN	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		

			COS	R
	Proper Use of Utensils			
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored 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		

Person in Charge (signature)

Inspector (signature) Peggy Spurley

Follow-up: Follow-up Date: