Electronically Delivered

December 2, 2025

Licensee
Walker Methodist Place
3701 Bryant Avenue South
Minneapolis, MN 55409

RE: Project Number(s) SL20447016

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 . . ."

IMPOSITION OF FINES

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

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

Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20447	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST PLACE	3701 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20447016-0 On October 27, 2025, through October 29, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 116 residents: 39 receiving services under the Assisted Living 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 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 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 27, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 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 a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of three employees (unlicensed personnel (ULP)-A). 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	0 660		

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0 660	Continued From page 4 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-A was hired on March 11, 2024, to provide assisted living services to residents. ULP-A's employee record included TB Screening and TB Risk Assessment completed on March 11, 2024, and a positive QuantiFERON TB Gold plus dated March 12, 2024. ULP-A's employee record also included a chest x ray (CXR) completed on October 9, 2023, 155 days prior to the positive QuantiFERON TB Gold plus result. ULP-A's record lacked evidence a CXR was completed within 90 days prior to the positive QuantiFERON TB Gold plus result or any time after the positive QuantiFERON TB Gold plus result. On October 29, 2025, at 12:45 p.m., regional registered nurse (RRN)-J stated there was no TB CXR to match the positive QuantiFERON TB Gold plus completed on March 12, 2024. RRN-J stated it was an oversight. The Minnesota Department of Health's frequently asked question website, under TB screening section, indicated each facility must establish and maintain a comprehensive tuberculosis (TB) infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease	0 660		

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0 660	Continued From page 5 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. A CXR alone is not acceptable documentation. You either need: - documentation of a positive two-step Tuberculin Skin Test (TST) or Interferon-Gamma Release Assay (IGRA) test, and - a CXR with provider evaluation after that date. or - documentation of refusal of both the two-step TST and IGRA, and - followed by a new CXR and provider evaluation. If the health care worker had a prior positive TB test result, and they only have the CXR but no other test documentation, then they need to take a new TB test. If the result is positive, a new CXR needs to be completed. The CXR needs to be done within 90 days of the positive test date or dated any time after the positive test date. The licensee's undated Tuberculosis Screening Policy indicated the CXR should be done after the date of the positive TB test or a CXR will be accepted if done within three months prior to the positive test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 6 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 28, 2025, the surveyor toured the facility with regional maintenance (RMX)-F and maintenance (MX)-G. The following was observed. FIRE DOOR OPERATION: The fire rated doors in resident rooms 807 and 802 would not close and latch on their own. There were 4 screws in the top of the door, and 2 screws in the top of the door frame that are consistent with door closers. When interviewed RMX-F agreed that it appeared that the doors were originally equipped with closers and stated that none of the resident room doors throughout the facility would be equipped with a closer.	0 775		

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0 775	Continued From page 7 Surveyor confirmed that none of the resident rooms surveyed were equipped with closers, but all showed evidence that they were equipped with closers previously. The fire rated door on the 8th floor laundry room would not close and latch on its own. Swinging fire doors shall close from the full-open position and latch automatically. PARKING GARAGE SIGNED EXIT DOORS: There were 3 signed exit doors from parking garage floors P1 and P2 leading into the stairwells. These doors were locked with a keyed deadbolt from the egress side. There were no other signed exit doors present in the parking garage. Egress doors shall be readily openable from the egress side without the use of a key or special knowledge or effort. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your	0 950		

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0 950	Continued From page 8 "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to include the required statutory language giving residents the right to identify a designated representative on its own separate page for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect 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:	0 950		

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0 950	Continued From page 9 R1's Assisted Living Contract was signed on March 6, 2025. R2's Assisted Living Contract was signed on September 9, 2025. R3's Assisted Living Contract was signed on July 24, 2025. R1, R2, and R3's assisted living contract did not include the required statutory notice language about a designated representative on a document separate from the contract. On October 29, 2025, at approximately 11:15 a.m., licensed assisted living director (LALD)-D stated they were aware of the required statutory language giving residents the right to identify a designated representative. LALD-D stated the language was not included in the licensee's contract and stated they would change the contract to include the required statutory language giving residents the right to identify a designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01500 SS=E	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include:	01500		

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01500	Continued From page 10 (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training 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 challenges it poses to communication; (2) the health impacts related to untreated	01500		

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01500	Continued From page 11 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 licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for two of three employees (unlicensed personnel (ULP)-A, ULP-H). 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: ULP-A ULP-A was hired on March 11, 2024, to provide assisted living services to residents. ULP-A's employee record contained a training record for the following required topics: - reporting maltreatment of vulnerable adults or	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20447	A. BUILDING: _____ B. WING _____	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER METHODIST PLACE	3701 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01500	Continued From page 12 minors; - assisted living bill of rights; - infection control techniques; and - review of provider's policies and procedures. ULP-A's employee record lacked documentation of eight hours of annual training completed for every 12 months employment, including the following required topics: - effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia or related disorders; and - principals of person-centered planning/service delivery. ULP-H ULP-H was on hired on June 17, 2024, to provide direct care to residents. ULP-H's employee record contained a training record for the following required topics: - assisted living bill of rights; - infection control techniques; and - review of provider's policies and procedures. ULP-H's employee record lacked documentation of eight hours of annual training completed for every 12 months employment, including the following required topics: - reporting maltreatment of vulnerable adults or minors; - effective approachesto use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia or related disorders; and - principals of person-centered planning/service delivery.	01500		

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01500	Continued From page 13 On October 29, 2025, at 12:34 p.m., licensed assisted living director (LALD)-D stated they were aware ULP-A did not complete their required training. LALD-D stated ULP-A had not worked a shift since the licensee discovered they were out of compliance with training, and ULP-A would not be working with residents until they became complaint. On October 29, 2025, at 1:25 p.m., LALD-D stated ULP-H was assigned all the required training, but they did not complete them all. LALD-D stated they did not know why it was not completed as they started the role of LALD for the licensee's location on September 6, 2025. The licensee's Education and Training policy indicated all team members are required to complete annual training. Team members not completing all required training may be subject to removal from the schedule and/or disciplinary action until such time as training is completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01500		
01530 SS=E	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental	01530		

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	20447	A. BUILDING: _____ B. WING _____	10/29/2025

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WALKER METHODIST PLACE	3701 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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01530	Continued From page 14 illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of three employees	01530		

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WALKER METHODIST PLACE	3701 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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01530	Continued From page 15 (unlicensed personnel (ULP)-A, ULP-H) received at least two hours of annual dementia care training for each 12 months of employment, and two hours of initial training on mental illness and de-escalation topics. 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: ULP-A ULP-A was hired on March 11, 2024, to provide assisted living services to residents. ULP-A's employee record lacked evidence to demonstrate ULP-A received the required two hours of annual dementia training and initial training on mental illness and de-escalation topics. ULP-H ULP-H was on hired on June 17, 2024, to provide direct care to residents. ULP-H's employee record included the following training: - de-escalation techniques 0.05 hours completed on September 23, 2025. ULP-H's employee record lacked evidence to demonstrate ULP-H received the required two hours of annual dementia training and the full two	01530		

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01530	Continued From page 16 hours of initial training on mental illness and de-escalation topics. On October 29, 2025, at 12:34 p.m., licensed assisted living director (LALD)-D stated they were aware ULP-A did not complete their required training. LALD-D stated ULP-A had not worked a shift the licensee discovered they were out of compliance with training, and ULP-A would not be working with residents until they became complaint. On October 29, 2025, at 1:25 p.m., LALD-D stated ULP-H was assigned all the required training, but they did not complete them all. LALD-D stated they did not know why it was not completed as they started the role of LALD for the licensee's location on September 6, 2025. The licensee's undated Education and Training policy indicated all team members are required to complete annual training. Team members not completing all required training may be subject to removal from the schedule and/or disciplinary action until such time as training is completed. Annual training topics included the following: - Effective approaches for providing care and communication for residents with challenging behaviors - Dementia Care Training topics include: a. Dementia-related behaviors b. Communication No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01640	Continued From page 17	01640		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (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 ensure the current service plan was implemented or revised and that all services required by the current service plan were provided according to the service plan for one of three 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	01640		

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01640	Continued From page 18 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: R2 was admitted to the licensee on August 12, 2024. R2's diagnoses included cerebrovascular accident (CVA) muscle weakness, presence of right artificial knee joint, hypertension, diabetes, degenerative disease of nervous system, and fever. R2's Service Plan Agreement dated August 8, 2025, indicated R2 received the following services: medication administration, bed transferring with EZ stand (a sit-to-stand patient lift), bathing with EZ stand, toileting with EZ stand, blood glucose check, grooming, and safety checks. On October 28, 2025, at approximately 8:35 a.m., the surveyor observed ULP-B assist R2 transfer from bed to wheelchair with use of a gait belt. ULP-B also assisted R2 to the bathroom with the gait belt and tried to help R2 to standing position. R2 stood up and held onto the grab bar by the toilet, R2 was unable to move their leg closer to the toilet and sat back down in the wheelchair. ULP-B helped R2 to a standing position three times with R2 unable to move their legs. The surveyor then observed ULP-B move the toilet riser seat closer to R2, and R2 sat down on the toilet seat. ULP-B pushed the toilet seat to the back of the toilet.	01640		

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01640	Continued From page 19 On October 28, 2025, 12:12 p.m., clinical nurse supervisor (CNS)-C stated R2 was supposed to be assisted with use of the EZ stand but R2 did not want to use it. CNS-S stated R2's daughter also did not want R2 to be assisted with the EZ stand. On October 28, 2025, at approximately 2:30 p.m., ULP-B stated they were supposed to use EZ stand for R2, but they did not. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
01870 SS=D	144G.71 Subd. 18 Medications provided by resident or family me When the assisted living facility is aware of any medications or dietary supplements that are being used by the resident and are not included in the assessment for medication management services, the staff must advise the registered nurse and document that in the resident record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were included in the assessment for medication management or documented in the resident record for medication or dietary supplement the resident was self-administering for one of four 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	01870		

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01870	Continued From page 20 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: R2 was admitted to the licensee on August 12, 2024. R2's diagnoses included cerebrovascular accident (CVA) muscle weakness, presence of right artificial knee joint, hypertension, diabetes, degenerative disease of nervous system, and fever. R2's Service Plan Agreement dated August 8, 2025, indicated R2 received the following services: medication administration, bed transferring with EZ stand (a sit-to-stand patient lift), bathing with EZ stand, toileting with EZ stand, blood glucose check, grooming, and safety checks. On October 28, 2025, at 9:40 a.m., the surveyor observed the following supplements in R2's room: - melatonin 10 milligram(mg); - Sleep 10mg full-spectrum CBD plus 3mg melatonin per serving; and - diclofenac sodium gel 1%. R2's Uniform Nursing Assessment dated July 15, 2025, medication management section, indicated R2 could not self-administer medication. On October 28, 2025, at 11:54 a.m., clinical nurse supervisor (CNS)-C stated R2 was not able to self-administer any medication. CNS-C	01870		

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01870	Continued From page 21 stated they were not aware R2 had the above-mentioned medications in their room. CNS-C stated R2's family might have brought the medications, and they did not communicate it to the nurse. CNS-C stated the ULPs were informed to let the nurses know when they see medications in the resident's room. On October 28, 2025, at 11:56 a.m., ULP-B stated they were aware R2 had the above-mentioned medications in their room, "it was on her table". On October 28, 2025, at 12:03 p.m., R2 stated they had been taking the sleep aide since they admitted to the licensee. R2 stated their daughter brought it for them and they had been self-administering. On October 28, 2025, at 12:05 p.m., CNS-C stated R2 did not have an order for the above-mentioned medications. The licensee's undated Medication Management Services over the counter medications and dietary supplements must maintain proper prescription labeling as is a standard with prescription drugs and supplied in bubble pack format (except for medications coming from the Veteran's Administration [VA]). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01870		

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

WALKER METHODIST PLACE
3701 BRYANT AVENUE SOUTH
Minneapolis, MN 55409
Hennepin County
Parcel:

Phone:

License Info

License: HFID 20447

Risk:
License:
Expires on:
CFPM: THOMAS PAUL GAETZ
CFPM #: 123131; Exp: 4/22/2027

Inspection Info

Report Number: F1029251252
Inspection Type: Full - Single
Date: 10/27/2025 Time: 12:15:15 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 2
Total Priority 3 Orders: 4
Delivery:

New Order: 2-100 Supervision
2-102.12DMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033D Post the certified food protection manager certificate.
COMMENT: PHOTOCOPY OF CFPM CERTIFICATE PRESENT. POST OFFICIAL MN CFPM CERTIFICATE.
Comply By: 10/31/2025 Originally Issued On: 10/27/2025

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: BUTTER PACKETS BEING LEFT AT AMBIENT FOR PROLONGED PERIODS THEN PLACED BACK INTO MECHANICAL REFRIGERATION. DISCARDED BY STAFF. STAFF INSTRUCTED TO DISCONTINUE PRACTICE WITHOUT A WRITTEN TPHC AND TIME TAGGING. STAFF INDICATED THEY WOULD BE DISCONTINUING PRACTICE AND PROVIDING PACKETS PER ORDER.

UPSTAIRS COOLER NOT MAINTAINING AT 41°F OR LESS. TEMPERATURE ABUSED ITEMS DISCARDED. STAFF INSTRUCTED TO VERIFY SAFE TEMPERATURES THROUGHOUT COOLER PRIOR TO USING IT FOR TCS FOODS.

Comply By: 10/27/2025 Originally Issued On: 10/27/2025

! **New Order: 3-500D Microbial Control: disposition of food**
3-501.18A *Priority Level: Priority 1 CFP#: 23*
MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.
COMMENT: SHREDDED COLESLAW MIX REMOVED FROM BAG AND PLACED INTO PLASTIC CONTAINER ON 10/20. DISCARDED BY STAFF. DATE MARKING REVIEWED.
Comply By: 10/27/2025 Originally Issued On: 10/27/2025

! **New Order: 4-500 Equipment Maintenance and Operation**
4-501.114C3 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.
COMMENT: QUATERNARY AMMONIUM FOUND TO BE BELOW SANITIZING LEVELS IN A WIPING CLOTH BUCKET AND SUBSEQUENTLY FROM THE DISPENSER. NEW SANIBUCKET HAND MIXED TO 400 PPM. STAFF INSTRUCTED TO REPAIR OR REPLACE THE DISPENSER AND HAND MIX SOLUTIONS AS A SHORT TERM FIX UNTIL THE DISPENSER IS REPAIRED OR REPLACED.
Comply By: 10/27/2025 Originally Issued On: 10/27/2025

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: QUAT DISPENSER AND UPSTAIRS COOLER NOT FUNCTIONING PROPERLY. ADJUST, REPAIR, OR REPLACE TO ENSURE SAFE SANITIZING CONCENTRATIONS AND COLD HOLDING TEMPERATURES.
Comply By: 10/27/2025 Originally Issued On: 10/27/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11A *Priority Level: Priority 2 CFP#: 16*
MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.
COMMENT: FOOD DEBRIS AND RESIDUES DRIED ONTO MEAT SLICER. STAFF INSTRUCTED TO CLEAN AFTER USE AND MAINTAIN CLEAN.
Comply By: 10/27/2025 Originally Issued On: 10/27/2025

New Order: 5-200A Plumbing: approved materials/design
5-201.11B *Priority Level: Priority 3 CFP#: 51*
MN Rule 4626.1040B Maintain the plumbing system in good repair.
COMMENT: HOLES IN HANDWASHING SINK BASINS AND ALONG METAL CONVEYOR AREA IN DISH PIT. STAFF INSTRUCTED TO SEAL.
Comply By: 10/31/2025 Originally Issued On: 10/27/2025

New Order: 5-500 Refuse and Recyclables
5-501.16C *Priority Level: Priority 3 CFP#: 54*
MN Rule 4626.1255C Provide a waste receptacle at each handwashing sink or group of handwashing sinks if disposable towels are used.
COMMENT: WASTE RECEPTACLES NOT BY HANDWASHING SINKS. STAFF INSTRUCTED TO PUT WASTE RECEPTACLES BY HANDWASHING SINKS.
Comply By: 10/27/2025 Originally Issued On: 10/27/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.111C *Priority Level: Priority 2 CFP#: 38*
MN Rule 4626.1565C Use approved trapping devices or other means of pest control when pests are found.
COMMENT: SNAP TRAPS PRESENT. STAFF INSTRUCTED TO REMOVE AND ONLY USED APPROVED TRAPPING DEVICES.
Comply By: 10/27/2025 Originally Issued On: 10/27/2025

Food & Beverage General Comment

Food and beverage inspection conducted as part of HRD survey of ALF. Identified correction orders reviewed with staff and nursing surveyor. Establishment commercial in nature excluding the memory care cooler and kitchen area, which is residential in nature and solely performs same day food and beverage services.

Food safety topics reviewed with staff: employee illness logging, exclusion, and notification requirements; employee hygiene and handwashing; temperature control; date marking and discarding after 7 days; common foodborne illness pathogens; protection from contamination; and pest control.

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 F1029251252 from 10/27/2025

Trevor McPliment

THOMAS GAETZ
CULINARY LEADER

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@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

WALKER METHODIST PLACE
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1029251252
Inspection Type: Full
Date: 10/27/2025
Time: 12:15:15 PM

New Record: **Product/Item/Unit:** BUTTER PACKET**; Temperature Process:** Cold-Holding
Location: 2-DOOR UPRIGHT at 45 Degrees F.
Comment: PACKETS OUT AT AMBIENT FOR SERVICE THEN PLACED BACK INTO COOER.
Violation Issued?: Yes

New Record: **Product/Item/Unit:** YOGURT**; Temperature Process:** Cold-Holding
Location: MEMORY CARE RESIDENTIAL COOLER at 46 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** BUTTER PACKETS**; Temperature Process:** Ambient Air
Location: ON COUNTER IN MEMORY CARE at 72 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** MILK**; Temperature Process:** Cold-Holding
Location: HOSHIZAKI UPRIGHT DELI COOLER at 42 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** INTERNAL THERMOMETER**; Temperature Process:** Cold-Holding
Location: SELF SERVE COOLER at 40 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** PASTA SAUCE**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** BAKED POTATO**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** MILK**; Temperature Process:** Cold-Holding
Location: 2-DOOR UPRIGHT COOLER at 39 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** NOODLE SOUP**; Temperature Process:** Hot-Holding
Location: Steam Table at 165 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** SLOPPY JOE MIX**; Temperature Process:** Hot-Holding
Location: Steam Table at 185 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** BREADED FISH FILLET**; Temperature Process:** COOKING
Location: JUST OUT OF FRYER at 155 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** MILK**; Temperature Process:** Cooling
Location: MEMORY CARE RESIDENTIAL COOLER at 44 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** PICKLE JUICE (NON-TCS)**; Temperature Process:** Cold-Holding
Location: MEMORY CARE RESIDENTIAL COOLER at 47 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** TUNA SALAD**; Temperature Process:** Cold-Holding
Location: TRAULSEN COOLER FREEZER COMBO at 37 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

WALKER METHODIST PLACE
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1029251252
Inspection Type: Full
Date: 10/27/2025
Time: 12:15:15 PM

Sanitizing Chemical: Product: QUATERNARY AMMONIUM**; Sanitizing Process:** Wiping Cloth Bucket
Location: Equal To 0 PPM
Comment:
Violation Issued?: Yes

Sanitizing Chemical: Product: QUATERNARY AMMONIUM**; Sanitizing Process:** Dispenser
Location: MOP CLOSET **Equal To** 0 PPM
Comment:
Violation Issued?: Yes

Sanitizing Equipment: Product: Hot Water**; Sanitizing Process:** Dish Machine
Location: Equal To 164.6 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: Product: QUATERNARY AMMONIUM**; Sanitizing Process:** Wiping Cloth Bucket
Location: Equal To 400 PPM
Comment: HAND MIXED
Violation Issued?: No