Electronically Delivered

December 22, 2022

Licensee
The Lodge on Summit Oaks
1412 Summit Oaks Drive
Burnsville, MN 55337

RE: Project Number(s) SL30445015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on November 22, 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.

LICENSING ORDERS
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 . . ."

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

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,

Jonathan Hill, Supervisor
State Rapid Response Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 651-201-3993 Fax: 651-281-9796

mpm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30445	A. BUILDING: _____ B. WING _____	11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE ON SUMMIT OAKS	1412 SUMMIT OAKS DRIVE BURNSVILLE, MN 55337

(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 Initial comments *****ATTENTION****** ASSISTED LIVING 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: SL30445015 On November 21, 2022, through November 22, 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 twelve (12) residents, all of whom received services under the provider's Assisted Living 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 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.	
0 480 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 21, 2022, for the specific	0 480		

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0 480	Continued From page 2 Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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 establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment, documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test and TB training for one of two employees (unlicensed personnel (ULP)-E).	0 660		

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0 660	Continued From page 3 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 resident's are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On November 21, 2022, at 1:45 p.m., the licensee's TB facility risk assessment indicated licensee was classified at a low risk setting. ULP-E had a start date of August 5, 2018. ULP-E's employee record did not contain the following: - completion of a TB history and symptom screen; - completion of a two-step TST or other evidence of TB screening such as a serum test. On November 22, 2022, at 2:14 p.m., operations manager (OM)-B confirmed the two-step TST or blood test was not completed as required for ULP-E. OM-B stated " ULP-E would be going to get TB tested on November 23, 2022, at 1:45 p.m.." The licensee's Tuberculosis Prevention and Control policy dated August 1, 2021, indicated that prior to contact with residents, each staff person would be screened for TB and a two-step skin test or single interferon gamma release assay (IGRA) for TB would be administered unless the person's past medical history indicates that a TB test is contraindicated. No further information was provided.	0 660		

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0 660	Continued From page 4 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; (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 have a written emergency disaster plan with all required content. This had	0 680		

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0 680	Continued From page 5 the potential to affect all twelve (12) residents receiving assisted living services, 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, 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 November 22, 2022, at 8:40 a.m., during review of the licensee's emergency preparedness plan, it was noted that the licensee's emergency preparedness was not posted in a common area, and the plan lacked the following required content: -current, all-hazards approach facility assessment -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations. -development of all policies/procedures, based on assessment; and additional policies for: -sheltering in place; -handling and use of volunteers; -arrangement with other facilities (including sister facilities); -EP training and testing program; -EP training program for staff (including documentation of training provided); -annual EP testing requirements. On November 22, 2022, at 9:50 a.m., operations manager (OM)-B confirmed the licensee's emergency preparedness plan was not posted in	0 680		

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0 680	Continued From page 6 a common area and that the plan lacked all the required content referenced above. The licensee's Disaster Planning and Emergency Preparedness Plan policy, dated May 1, 2015, indicated the licensee would have in place a written plan of action to facilitate the management of resident's care and services in response to a natural disaster or other emergencies that may disrupt their ability to provide care and/or services. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to install and maintain monthly visual inspections on portable fire extinguishers in accordance with the State	0 790		

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0 790	Continued From page 7 Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly 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 21, 2022, approximately from 1:30 p.m. to 3:15 p.m. survey staff toured the facility with the operations manager (OM)-B. During the tour, survey staff observed and the OM-B confirmed the following: 1) The portable fire extinguishers provided in the facility were serviced with an annual service date of June 2022 but lacked records to show the monthly visual inspections. Survey staff explained to the OM-B that the portable fire extinguishers must also be provided with monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable, at their designated location, and no obvious physical damage or condition to the extinguisher to prevent their operation when needed. 2) The portable fire extinguisher unit located in a corner near the nurse area and resident room 108 was not mounted and secured as required. Survey staff pointed out to the OM-B the unit sitting on the floor.	0 790		

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0 790	Continued From page 8 On November 21, 2022, at approximately 4:00 p.m., during the exit interview, the OM-B acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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 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) 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).	0 800		

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0 800	Continued From page 9 On November 21, 2022, approximately from 1:30 p.m. to 3:15 p.m. survey staff toured the facility with the operations manager (OM)-B. During the tour, survey staff observed and the OM-B confirmed the following: 1) The main water shut-off valve was located inside a closet buried and covered by boxes and personal items which obstructed the valve to be readily accessible for shut off during an emergency. 2) The corridor leading to an exit door on the lower level was used as storage and blocked by wheelchairs, furniture, and equipment restricting a path or means to properly move safely to the door in case of an emergency for safe egress. The OM-B verified the finding as she had cleared out the obstructions. 3) The hallway wall (corridor) on the lower-level floor had damaged sheetrock in multiple areas of the wall compromising the smoke-tight fire protection construction of the corridor for safe egress. 4) The emergency lights located in the hallway (corridor) were not in working order for emergency use. 5) The lighting in resident room 101 and the stairway to the lower level was not in working order. 6) The door to resident room 107 had a door hasp hardware that can be locked in the means of egress if a lock was installed on the outside of the room that would restrict exiting from inside the room. Survey staff explained to the OM-B that the hasp hardware must be removed from any accidental locking of the door restricting egress for the resident from the inside during an emergency. The OM-B stated that she will remove the hasp hardware immediately. 7) In resident room 108, survey staff observed	0 800		

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0 800	Continued From page 10 below the egress window was a dresser and in surrounding areas of the egress window were cluttered and stacked with excessive clothing and household items obstructing ready access to the egress window in case of emergency. 8) The fire alarm control panel located inside the laundry room had an electronic error that noted "Trouble 1". 9) The annual fire alarm detection system inspection and test records from the qualified contractor were requested from the OM-B to ensure the fire alarm and smoke detection system were maintained and to ensure all smoke detectors/alarms were in working order but were not available. 10) The exhaust fans in the main level staff restroom and laundry room were missing a cover. 11) In the lower-level resident room 10, extension cords were near used which posed safety concerns of potential electrical fire hazards from overloading the electrical circuits. 12) Oxygen cylinders were located in a corner of the corridor next to resident rooms 107/108 and an exit door on the main floor level which posed a potential enriched oxygen environment in a means of egress path in case of a fire. The OM-B confirmed the finding as she stated that the cylinders were for the previous resident in room 105 and they no longer have residents on oxygen. On November 21, 2022, at approximately 4:00 p.m., during the exit interview, the OM-B acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		

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0 810	Continued From page 11	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (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 observation, record review, and	0 810		

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0 810	Continued From page 12 interview, the licensee failed to provide the facility's fire safety and evacuation procedures, employee evacuation drills, and the required training on fire safety and evacuation. This has the potential to directly affect the safety of all residents receiving services, 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 21, 2022, at approximately 3:15 p.m., survey staff asked for the facility fire safety and evacuation plan, evacuation drills, and training documentation for review from the operations manager (OM)-B. The OM-B explained that they did not have the requested documentation including drill records because the documentation was at their Mendota Heights location from the recent survey by the health department. 1. The licensee failed to have a Burnsville site-specific fire safety and evacuation plan and to have it readily available (at all times) within the facility. -No facility-specific employee fire safety procedures or evacuation plans readily available for review. The plan must have specific employee actions to be taken in case of fire or similar emergency necessary for the residents including procedures for their movements, and relocation during a fire or similar, and have instructions for	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30445	A. BUILDING: _____ B. WING _____	11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE ON SUMMIT OAKS	1412 SUMMIT OAKS DRIVE BURNSVILLE, MN 55337

(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
0 810	Continued From page 13 addressing any unique situation during an evacuation, especially for residents needing assistance during an evacuation. -No fire protection procedures necessary for residents. -The posted floor layout plan lacked the location and number of resident sleeping rooms. 2) No policy, and/or records on the training of employees on fire safety and evacuation were available for review. 3) No policy, and/or records of required employee evacuation drills were provided for review. 4) No required record of training of residents who are capable of assisting their own evacuation on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. No records were provided for review. Minnesota statutes require the licensee to develop and maintain a fire safety and evacuation plan readily available within the facility at all times. In addition, employees are required to complete evacuation drills for the facility for the Burnsville location and performed training to prevent delayed response time for the evacuation of residents and employees during a fire or emergency. On November 21, 2022, at approximately 4:00 p.m. the OM-B verified the findings as she was not able to provide the requested information listed above for review for this survey. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30445	A. BUILDING: _____ B. WING _____	11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE ON SUMMIT OAKS	1412 SUMMIT OAKS DRIVE BURNSVILLE, MN 55337

(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
0 970	Continued From page 14	0 970		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for resident health, safety, or personal property. This had the potential to affect all residents. 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: During R1 record review on November 22, 2022, at 10:50 a.m., the surveyor noted contract language for R1 included that licensee would not insure resident for liability losses. R1's Assisted Living Contract included a section for Liability that read, "The Lodges Co. insures itself against liability losses, but it does not insure	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30445	A. BUILDING: _____ B. WING _____	11/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 970	Continued From page 15 resident for liability losses, and licensee recommends that resident use proper precautions to guard themselves against possible loss." On November 22, 2022, at approximately 3:00 p.m., operations manager (OM)-B confirmed the licensee's assisted living contract included the above content, and stated the same contract was utilized for all residents at the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *11/21/22*
Time: 10:26:58
Report: 1018221188

Food and Beverage Establishment Inspection Report

Location:
The Lodge On Summit Oaks
1412 Summit Oaks Drive
Burnsville, MN55337
Dakota County, 19

Establishment Info:
ID #: 0037582
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122000901
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.

4-500 Equipment Maintenance and Operation

4-501.112A ** Priority 2 **

MN Rule 4626.0795A Maintain the temperature at the manifold of the hot water sanitizing rinse at a maximum temperature of 194 degrees F (90 degrees C) and no less than 165 degrees F (74 degrees C) for a single tank, stationary rack, single temperature machine or 180 degrees F (82 degrees C) for all other machines.

DISHWASHER THAT THE ESTABLISHMENT USES FOR SANITIZING IS NOT REACHING THE PROPER TEMPERATURE AND IS NOT FUNCTIONING PROPERLY. DISCUSSED WITH MANAGER TO REPAIR THE DISHWASHER OR OBTAIN A 3 COMPARTMENT SINK FOR DISH WASHING AND SANITIZING.

Comply By: 11/22/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CERTIFIED FOOD MANAGER ON SITE. COMPLY WITH RULE.

Comply By: 02/01/23

Surface and Equipment Sanitizers

Hot Water: = at 73F Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: Yes

Food and Equipment Temperatures

Type: Full
Date: *11/21/22*
Time: 10:26:58
Report: 1018221188
The Lodge On Summit Oaks

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding/ DELI MEAT
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: Cold Holding/ TURKEY
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

INSPECTION CONDUCTED WITH RHONDA MAKELA (MDH) PRESENT.

FIRM HAS ALL COMMERCIAL EQUIPMENT IN THE KITCHEN.

PHYSICAL FACILITIES OBSERVED IN GOOD CONDITION.

DISCUSSED EMPLOYEE ILLNESS AND ILLNESS REPORTING.

SANITIZING WILL BE DONE IN A BUCKET SYSTEM UNTIL THE ESTABLISHMENT CAN REPAIR THEIR DISHWASHER OR OBTAIN A 3 COMPARTMENT SINK.

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 1018221188 of 11/21/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
IVY JO STRUBE
KITCHEN MANAGER

Signed: 
Rebecca Prestwood
Sanitarian 3
6512013777
rebecca.prestwood@state.mn.us