DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

April 15, 2026

Licensee
Walker Methodist River Heights
744 19th Avenue North
S St Paul, MN  55075

RE: Project Number(s) SL21583016

Dear Licensee:

On April 13, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 14, 2026. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

KKM

Electronically Delivered

February 4, 2026

Licensee
Walker Methodist River Heights
744 19th Avenue North
S St Paul, MN  55075

RE:  Project Number(s) SL21583016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 14, 2026, 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.

**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:

**0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00**
**2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL21583016-0<br><br>On January 12, 2026, through January 14, 2026, 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 42 residents; 42 receiving services under the Assisted Living Facility with Dementia Care license.<br><br>2310: An immediate order was issued on January 13, 2026, at a level 3/Isolated (G). Immediate action was taken to mitigate risk; however, scope and level remains at G. | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services | 0 480 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 0 480 | Continued From page 1<br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(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;<br>(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;<br>(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;<br>(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;<br>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are | 0 480 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 0 480 | Continued From page 2<br><br>allowed provided the facility keeps them clean and in good condition;<br>(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<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 12, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer | 0 480 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 0 480 | Continued From page 3<br>to the FBEIR for any compliance dates. | 0 480 | | |
| 0 730 SS=F | 144G.43 Subd. 3 Contents of resident record<br><br>Contents of a resident record include the following for each resident:<br>(1) identifying information, including the resident's name, date of birth, address, and telephone number;<br>(2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative;<br>(3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known;<br>(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;<br>(5) the resident's advance directives, if any;<br>(6) copies of any health care directives, guardianships, powers of attorney, or conservatorships;<br>(7) the facility's current and previous assessments and service plans;<br>(8) all records of communications pertinent to the resident's services;<br>(9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;<br>(11) documentation that services have been | 0 730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 0 730 | Continued From page 4<br><br>provided as identified in the service plan;<br>(12) documentation that the resident has received and reviewed the assisted living bill of rights;<br>(13) documentation of complaints received and any resolution;<br>(14) a discharge summary, including service termination notice and related documentation, when applicable; and<br>(15) other documentation required under this chapter and relevant to the resident's services or status.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to include the required content in a discharge summary for one of one discharged resident (R5).<br><br>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).<br><br>The findings include:<br><br>R5 was admitted to the licensee on August 22, 2024, and discharged on July 15, 2025, to a skilled nursing facility.<br><br>R5's record included a Death or Discharge Summary dated July 15, 2025; however, it did not include the following required content:<br>-a summary of the resident's stay that includes diagnoses, course of illnesses, allergies, | 0 730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 0 730 | Continued From page 5<br><br>treatments and therapies and pertinent lab, radiology, and consultation results;<br>-a final summary of the resident's status from the latest assessment or review under Minnesota Statues, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status;<br>-a reconciliation of all predischarge medications with the resident's post discharge prescribed and over-the-counter medications; and<br>-a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need.<br><br>On January 14, 2026, at 10:16 a.m., clinical nurse supervisor (CNS)-B reviewed R5's discharge summary and stated it did not include the required content as listed above. CNS-B stated she may have provided the wrong discharge summary report and would review R2's record for an updated discharge summary.<br><br>On January 14, 2026, at 11:35 a.m., CNS-B stated she could not locate a different discharge summary for R2. CNS-B stated the same discharge summary was used for all residents.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 0 775 | Continued From page 6 | 0 775 | | |
| 0 775 SS=F | 144G.45 Subd. 2. (a) Fire protection and physical environment<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 775 | | |
| 01060 SS=D | 144G.52 Subd. 9 Emergency relocation<br><br>(a) A facility may remove a resident from the | 01060 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01060 | Continued From page 7<br>facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;<br>(4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and<br>(5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal.<br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and<br>(3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.<br>(d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes | 01060 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01060 | Continued From page 8<br><br>a termination and triggers the termination process in this section.currently known; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R2).<br><br>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).<br><br>The findings include:<br><br>R2 was admitted on January 31, 2022, with diagnoses that included diabetes.<br><br>R2's progress notes dated November 6, 2025, indicated R2 was sent to the emergency room via emergency medical services (EMS) after R2 complained of not feeling well. R2 was admitted to the hospital.<br><br>R2's progress notes dated November 12, 2025, indicated R2 returned to the licensee (six days later).<br><br>R2's record contained a Notification of Emergency Relocation that was provided to R2 and R2's legal representative. However, R2's record lacked notification to the Office of Ombudsman for Long-Term Care the resident | 01060 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01060 | Continued From page 9<br><br>had been relocated and had not returned to the facility within four days.<br><br>On January 14, 2026, at 10:09 a.m., clinical nurse supervisor (CNS)-B stated she thought she sent the notification to the Office of Ombudsman for Long-Term Care for R2; however, she could not locate documentation of the notification.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT: Twenty-one (21) days | 01060 | | |
| 01640 SS=D | 144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to<br><br>(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.<br>(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.<br>(c) The facility must implement and provide all services required by the current service plan.<br>(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.<br>(e) Staff providing services must be informed of the current written service plan. | 01640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01640 | Continued From page 10<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for two of three residents (R2 and R3).<br><br>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).<br><br>The findings include:<br><br>R2:<br>R2 was admitted on January 31, 2022, with diagnoses that included diabetes.<br><br>On January 13, 2026, at 8:08 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R2. R2 was wearing oxygen via nasal cannula.<br><br>R2's Service Plan Agreement dated October 13, 2025, indicated R2 received assistance with bathing, safety checks, thrombo-embolic deterrent (TED) Stockings (stockings designed to prevent blood clots and decrease swelling in legs), and medication administration.<br><br>R2's medication administration record (MAR) dated January 2026, included the following:<br>-Oxygen via Nasal Cannula: Check oxygen | 01640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01640 | Continued From page 11<br><br>concentrator to ensure it is set at 2 liters. If it is not, alert nursing.<br><br>R2's service checkoff list dated January 2026, included the following services:<br>-Oxygen Assist: Ensure nasal cannula is on, oxygen tubing is not kinked or tangled, and ensure oxygen concentrator is at the ordered flow rate, which is between 1-3 liters per minute. Alert nurse, if oxygen is not within ordered range. RA (resident assistant) to assist resident with oxygen, check oxygen rate, assist to place oxygen cannula.<br>-Oxygen Assist: Check oxygen cylinders to see if refill is needed<br>-Weight Monitor: Review last week's weights. Report to provider if resident has a 5+ pound weight gain in the last week. Obtain and document resident weight.<br>-Licensed Nurse Service: Wound: RN to complete basic wound care to left ear one time a week on Wednesday. Cleanse with wound cleanser, pat dry, apply band aid. Wound care performed by nurse.<br><br>R2's services received document for weights dated November 2025, through January 2026, indicated the staff checked R2's weight three times a week.<br><br>R2's signed prescriber orders included the following:<br>-Oxygen 2 liters per minute via nasal cannula continuously, order dated November 12, 2025<br>-Check weight three times a week, update primary if gains more than five pounds in a week, order dated November 13, 2025<br>-Hospice to perform wound care to left ear twice weekly, on Monday and Friday. Facility nursing to perform wound care one time weekly on | 01640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01640 | Continued From page 12<br><br>Wednesday. Nurse to cleanse wound with wound cleanser and cover with band aid, order dated January 14, 2026<br><br>R2's service plan agreement did not include oxygen, three times a week weight monitoring and wound care.<br><br>R3<br>R3 was admitted on November 6, 2025, with diagnoses that included diabetes.<br><br>On January 13, 2026, at 7:23 a.m., the surveyor observed ULP-G check R3's blood sugar via Libre Sensor (continuous glucose monitoring).<br><br>R3's Service Plan Agreement dated November 6, 2025, indicated R3 received services to include grooming, dressing, bathing, TED stockings, toileting, meal reminders, safety checks, blood glucose checks (4 x/day), and medication administration.<br><br>R3's MAR dated January 2026, included the following:<br>-Freestyle Libre 3 plus Sensor: use as directed to check blood sugar and change every 15 days<br><br>R3's service checkoff list dated January 2026, included the following:<br>-Licensed Nurse Service: Wound: left foot wound: soak small piece of gauze with vashe and leave on wound for five minutes, apply small piece of alginate with iodosorb, cover with dry gauze and tape. Facility nurse to complete Monday, Wednesday and as needed (PRN) and wound care nurse to complete on Fridays.<br><br>R3's signed prescriber orders dated November 5, 2025, included the following: | 01640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01640 | Continued From page 13<br><br>-Blood glucose sensor (Free Style Libre 3 Plus Sensor): to be used to read blood sugars, change sensor every 15 days<br>-Blood glucose checks before meals and at bedtime<br>-Vashe: soak piece of gauze with Vashe and leave on wound for five minutes. Apply Iodosorb (orange paste), with small Q-Tip to open part of wound. Paint around wound with Betadine. Apply Alginate (cute a small piece) over the wound. Cover with dry gauze and tape. Change three times a week. Keep pressure off wound.<br><br>R3's service plan agreement did not include Free Style Libre Sensor changes and wound care.<br><br>On January 14, 2026, at 10:12 a.m., clinical nurse supervisor (CNS)-B reviewed R2 and R3's service plans and stated they did not include the services listed above. CNS-B stated the surveyor was not given the most current service plan and would provide the updated service plans.<br><br>On January 14, 2026, at 11:16 a.m., CNS-B provided service plans, both dated January 14, 2026, that included the missing services; however, the service plans were created after the start of survey and were not signed by the residents/resident representative or the licensee.<br><br>The licensee's Resident Assessments and Service Agreements policy dated December 2025, indicated a service agreement is a written plan describing the services to be provided to a resident, including frequency, scope, and general care approach. When resident needs change, services and service agreements may be adjusted based on RN reassessment and discussion with the resident or responsible party. | 01640 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01640 | Continued From page 14<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01640 | | |
| 01730 SS=F | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to documenting medication administration, | 01730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01730 | Continued From page 15<br><br>verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for two of two residents (R1 and R3) with insulin.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on January 12, 2026, at approximately 9:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents living at the facility. CNS-B stated the licensee stored medication in medication carts, and a refrigerator. | 01730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01730 | Continued From page 16<br><br>R1<br>R1 was admitted on May 6, 2020, with diagnoses that included diabetes.<br><br>On January 13, 2026, at 7:51 a.m., the surveyor observed unlicensed personnel (ULP)-D administer insulin to R1.<br><br>R1's Service Plan Agreement dated September 26, 2025, indicated R1 received services to include medication administration.<br><br>R1's Medication Management Services (found within the service plan agreement) dated September 26, 2025, indicated the following:<br>-All medications will be kept in a durable, locked medication cart and all narcotic medications will be double locked in the medication cart per state and federal regulations.<br><br>R1's medication administration record (MAR) dated January 2026, included the following orders:<br>-Novolog 70-30 Flexpen: inject 24 units subcutaneously once daily before breakfast<br>-Novolog 70-30 Flexpen; inject 22 units subcutaneously once daily before dinner.<br><br>R1's medication management plan lacked the following required content:<br>-central storage refrigeration for insulin<br><br>R3<br>R3 was admitted on November 6, 2025, with diagnoses that included diabetes.<br><br>On January 13, 2026, at 7:23 a.m., the surveyor observed ULP-G check R3's blood sugar via Libre Sensor (continuous glucose monitoring). | 01730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01730 | Continued From page 17<br><br>R3's Service Plan Agreement dated November 6, 2025, indicated R3 received services to include medication administration.<br><br>R3's Medication Management Services (found within the service plan agreement) dated November 6, 2025, indicated the following:<br>--All medications will be kept in a durable, locked medication cart and all narcotic medications will be double locked in the medication cart per state and federal regulations.<br><br>R3's MAR dated January 2026, included the following:<br>-Insulin Aspart 100 unit/milliliter (ml); inject 6 units subcutaneously twice daily at breakfast and dinner<br>-Insulin Aspart 100 units/ml; inject 8 units subcutaneously Once daily at lunch<br>-Lantus solostar 100 units/ml; inject 17 units subcutaneously every night at bedtime<br><br>R3's medication management plan lacked the following required content:<br>-central storage refrigeration for insulin<br><br>On January 14, 2026, at 10:19 a.m., regional director of operations (RDOO)-K and CNS-B reviewed R1 and R3's medication management plans and stated none of the residents with insulin have refrigeration included for insulin storage.<br><br>The licensee's Medication Management Services policy dated January 2025, indicated an individualized medication management plan will be prepared, and a written statement of the medication management service that will be provided to the resident will be included on the | 01730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01730 | Continued From page 18<br><br>service agreement. The medication management services record for each resident will include:<br>a. a service statement describing which medication management services will be provided<br>b. a description of the storage of medication based on the resident's needs, risk of diversion, and consistent with the manufacturer's direction<br>c. documentation of specific resident instructions relating to the administration of medication will be included in the MAR, as needed<br>d. identification of person(s) responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis<br>e. identification of medication management task that may be delegated to ULP<br>f. procedures for staff notifying a RN when a problem arises with medication administration<br>g. any resident specific requirements relating to documentation of medication administration, verifications that all medications are administered as prescribed, and monitoring and evaluating of medication used to prevent possible complications or adverse reactions<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |
| 01770 SS=F | 144G.71 Subd. 9 Documentation of medication setup<br><br>Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.<br><br>This MN Requirement is not met as evidenced | 01770 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01770 | Continued From page 19<br><br>by:<br>Based on observation, interview, and record review, the licensee failed to ensure documentation of medication set up included all the required content for one of one resident (R4).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>During the entrance conference on January 12, 2026, at approximately 9:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to their residents, including medication set up.<br><br>R4 was admitted on January 17, 2022, with diagnoses that included hypertension (high blood pressure).<br><br>R4's Service Plan Agreement dated October 5, 2025, indicated R4 received services to include medication setup.<br><br>R4's service received document dated December 2, 2025, through January 6, 2026, indicated a nurse set up R4's medications on December 2, 9, 16, 23, and 30, 2025.<br><br>R4's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be | 01770 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01770 | Continued From page 20<br>administered, and route of administration.<br><br>On January 14, 2026, at 10:13 a.m., CNS-B reviewed R4's medication setup document and stated it did not include the required content as noted above. CNS-B stated she thought a different report could be printed that would include the required documentation for medication setup. However, no additional documentation was provided.<br><br>The licensee's Medication Management Services policy dated January 2025, indicated documentation of medication set-up must be done at the time of set-up and must include the following:<br>-the date of medication set-up<br>-medication name, dose, time route of administration<br>-name of person completing set-up<br>-a copy of the medication administration record (MAR)<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT: Seven (7) Days | 01770 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by: | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01890 | Continued From page 21<br><br>Based on observation, interview, and record review, the licensee failed to ensure insulin pens had a pharmacy label for one of two residents (R1).<br><br>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).<br><br>The findings include:<br><br>R1 was admitted on May 6, 2020, with diagnoses that included diabetes.<br><br>R1's Service Plan Agreement dated September 26, 2025, indicated R1 received services to include medication administration.<br><br>R1's medication administration record (MAR) dated January 2026, included the following orders:<br>-Novolog 70-30 Flexpen: inject 24 units subcutaneously once daily before breakfast<br>-Novolog 70-30 Flexpen; inject 22 units subcutaneously once daily before dinner.<br><br>On January 13, 2026, at 7:51 a.m., the surveyor observed unlicensed personnel (ULP)-D administer 24 units of Novolog insulin to R1. The Novolog insulin pen did not have a pharmacy label on it.<br><br>On January 14, 2026, at 10:17 a.m., clinical nurse supervisor (CNS)-B stated the pharmacy label | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01890 | Continued From page 22<br><br>must have fallen off of R1's insulin pen. CNS-B stated she would educate the ULP that if a label fell off of an insulin pen, the nurse would reattach it with tape.<br><br>The licensee's Medication Storage and Labeling policy dated November 1, 2025, indicated all medications and biologicals must be labeled in accordance with federal and state regulations and accepted pharmaceutical principles. Label requirements include:<br>-resident's name<br>-prescribing provider's name<br>medication name (generic and/or brand)<br>-strength, dose, quantity<br>-prescription number (if applicable)<br>-date dispensed<br>-administration instructions and precautions (e.g., shake well, take with food, do not crush)<br>-expiration date<br>-route of administration<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 01910 SS=D | 144G.71 Subd. 22 Disposition of medications<br><br>(a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.<br>(b) The facility shall dispose of any medications remaining with the facility that are discontinued or | 01910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01910 | Continued From page 23<br><br>expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.<br>(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required for one of one discharged resident (R5).<br><br>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).<br><br>The findings include:<br><br>R5 was admitted to the licensee on August 22, 2024, and discharged on July 15, 2025.<br><br>R5's Medication Disposition/Disposal Record form had seven columns that identified the date, medication, prescription number, quantity, method of disposition, registered nurse (RN) signature, and staff signature. R2's disposition record did not include the strength/dose of each | 01910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01910 | Continued From page 24<br>medication listed.<br><br>On January 14, 2026, at 10:14 a.m., clinical nurse supervisor (CNS)-B reviewed R5's disposition record and stated it did not include the strength/dose of each medication. Regional director of clinical services (RDOCS)-L stated a new disposition form had been created which included a column for medication strength/dose and the licensee would use this going forward.<br><br>The licensee's Medication Return and Destruction policy dated November 1, 2025, indicated a non-controlled medication destruction record will be maintained, including:<br>-facility name and address<br>-medication details (name, strength, quantity, lot/prescription number)<br>-date destroyed<br>-reason and method of destruction<br>-signatures of witnesses<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01910 | | |
| 01970 SS=D | 144G.72 Subd. 6 Treatment and therapy orders<br><br>There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. | 01970 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01970 | Continued From page 25<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were maintained for one of three residents (R2) receiving treatments.<br><br>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).<br><br>The findings include:<br><br>R2 was admitted on January 31, 2022, with diagnoses that included diabetes.<br><br>On January 13, 2026, at 8:08 a.m., the surveyor observed unlicensed personnel (ULP)-F administer medications to R2. R2 was wearing oxygen via nasal cannula.<br><br>R2's Service Plan Agreement dated October 13, 2025, indicated R2 received assistance with bathing, safety checks, thrombo-embolic deterrent (TED) Stockings (stockings designed to prevent blood clots and decrease swelling in legs), and medication administration. R2's service plan did not include oxygen, three times a week weight monitoring, wound care and blood glucose checks.<br><br>OXYGEN:<br>R2's medication administration record (MAR) | 01970 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01970 | Continued From page 26<br><br>dated January 2026, included the following:<br>-Oxygen via Nasal Cannula: Check oxygen concentrator to ensure it is set at 2 liters. If it is not, alert nursing.<br><br>R2's service checkoff list dated January 2026, included the following services:<br>-Oxygen Assist: Ensure nasal cannula is on, oxygen tubing is not kinked or tangled, and ensure oxygen concentrator is at the ordered flow rate, which is between 1-3 liters per minute. Alert nurse, if oxygen is not within ordered range. RA (resident assistant) to assist resident with oxygen, check oxygen rate, assist to place oxygen cannula.<br><br>R2's signed prescriber orders dated November 12, 2025, included the following:<br>-Oxygen 2 liters per minute via nasal cannula continuously<br><br>R2's record did not include instructions regarding when to administer 1 liter, 2 liters or 3 liters of oxygen via nasal cannula.<br><br>WOUND CARE:<br>R2's service checkoff list dated January 2026, included the following service:<br>-Licensed Nurse Service: Wound: RN to complete basic wound care to left ear one time a week on Wednesday. Cleanse with wound cleanser, pat dry, apply band aid. Wound care performed by nurse.<br><br>R2's signed prescriber orders included the following:<br>-Hospice to perform wound care to left ear twice weekly, on Monday and Friday. Facility nursing to perform wound care one time weekly on Wednesday. Nurse to cleanse wound with wound | 01970 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01970 | Continued From page 27<br><br>cleanser and cover with band aid, order dated January 14, 2026<br><br>R2's prescriber orders for wound care were obtained on January 14, 2026, after the start of survey.<br><br>BLOOD GLUCOSE CHECKS:<br>R2's signed prescriber orders dated November 12, 2025, included the following:<br>-Blood glucose testing: resume your previously recommended checks by your provider<br>-Accucheck (blood glucose) checks four times daily (before meals and bedtime)<br><br>R2's record lacked evidence that the licensee checked R2's blood glucose.<br><br>On January 14, 2026, at 10:26 a.m., clinical nurse supervisor (CNS)-B stated R2's oxygen order is for 2 liters continuously per nasal cannula and should not indicate the staff could administer between 1-3 liters of oxygen. CNS-B stated the wound care order was obtained from hospice after she was unable to locate a current order in R2's record. CNS-B stated the licensee was not checking R2's blood glucose. CNS-B stated she reviewed R2's record and could only locate an order to discontinue blood glucose checks from 2023, prior to her employment with the licensee. CNS-B stated she would notify R2's primary care provider to clarify if R2 required blood glucose checks.<br><br>The licensee's Treatment and Therapy Management policy dated January 2025, indicated an up-to-date written or electronically recorded order from an authorized prescriber will be obtained for all treatments and therapies. The order must include: | 01970 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 01970 | Continued From page 28<br>1. Name of resident<br>2. Description of treatment or therapy<br>3. Frequency and duration and other information needed to administer the treatment or therapy<br>4. Must be renewed at least every 12 months<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01970 | | |
| 02170 SS=F | 144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA<br><br>(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:<br>(1) past and current interests;<br>(2) current abilities and skills;<br>(3) emotional and social needs and patterns;<br>(4) physical abilities and limitations;<br>(5) adaptations necessary for the resident to participate; and<br>(6) identification of activities for behavioral interventions.<br>(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.<br>(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:<br>(1) occupation or chore related tasks;<br>(2) scheduled and planned events such as entertainment or outings; | 02170 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 02170 | Continued From page 29<br><br>(3) spontaneous activities for enjoyment or those that may help defuse a behavior;<br>(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;<br>(5) spiritual, creative, and intellectual activities;<br>(6) sensory stimulation activities;<br>(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and<br>(8) outdoor activities.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions for two of three residents (R1 and R2) who received services under the assisted living with dementia care license and resided in the secure memory care unit.<br><br>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).<br><br>The findings include:<br><br>The licensee had an assisted living with dementia care license.<br><br>R1<br>R1 was admitted on May 6, 2020, with diagnoses that included diabetes. | 02170 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 02170 | Continued From page 30<br><br>On January 13, 2026, at 7:51 a.m., the surveyor observed unlicensed personnel (ULP)-D administer insulin to R1.<br><br>R1's Interest Inventory dated January 20, 2023, included past and current interests. R1's record lacked the following:<br>-current abilities and skills<br>-emotional and social needs and patterns<br>-physical abilities and limitations<br>-adaptations necessary for the resident to participate; and<br>-identification of activities for behavioral interventions<br><br>R2<br>R2 was admitted on January 31, 2022, with diagnoses that included diabetes.<br><br>On January 13, 2026, at 8:08 a.m., the surveyor observed ULP-F administer medications to R2.<br><br>R2's Interest Inventory dated October 10, 2023, included past and current interests. R2's record lacked the following:<br>-current abilities and skills<br>-emotional and social needs and patterns<br>-physical abilities and limitations<br>-adaptations necessary for the resident to participate; and<br>-identification of activities for behavioral interventions<br><br>On January 14, 2026, at 10:26 a.m., licensed assisted living director (LALD)-A stated the life enrichment coordinator worked with the resident and/or resident representative to complete the Interest Inventory for each resident. LALD-A stated he was not aware the document did not | 02170 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 02170 | Continued From page 31<br><br>include all required content. Regional director of operations (RDOO)-K reviewed R1 and R2's interest inventory documents and reviewed the Assisted Living Laws and Rules with the surveyor which listed what was required within the activity evaluation. RDOO-K stated the current activity evaluation used for residents did not include the required content as noted above.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 02170 | | |
| 02310 SS=G | 144G.91 Subd. 4 (a) Appropriate care and services<br><br>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for one of two residents (R2) with bed rails. This resulted in an immediate correction order issued on January 13, 2026.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 32<br><br>limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R2 was admitted on January 31, 2022, with diagnoses that included diabetes and dementia.<br><br>R2's Service Plan Agreement dated October 13, 2025, indicated R2 received assistance with bathing, safety checks, thrombo-embolic deterrent (TED) stockings (stockings designed to prevent blood clots and decrease swelling in legs), and medication administration.<br><br>On January 13, 2026, at 8:15 a.m., the surveyor observed R2's bed to have an upside down "C" shaped consumer bed rail attached on the right side of the bed. R2 stated her family provided the bed rail and couldn't remember who installed it. R2 stated she used the bed rail to help get in and out of bed and repositioning.<br><br>On January 13, 2026, at 9:29 a.m., the surveyor and environmental services manager (ESM)-I observed the bed rail attached to R2's bed. ESM-I stated R2's family provided the bed rail, and he attached it to the bed.<br><br>R2's record contained the following documents regarding bed rails:<br>-Informed Choice Consent for Physical Devices documented dated Janaury 18, 2024, which R2 selected and signed the "I do not give my approval for the physical device listed above" option. The device listed was a bed cane.<br>-Prescriber orders dated May 23, 2024, that included "ok for bilateral halo bars to assist with transfers and bed mobility" | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 33<br><br>-Halo Safety Ring Instructions<br>-Bed System Measurement Device Test Results-AL document dated October 7, 2025, that indicated ESM-I installed a bedrail to a standard mattress. The document did not indicate the type of bedrail that was installed.<br><br>R2's record contained the above bed rail documents Halo bar bed rail; however, R2 does not utilize a Halo bed rail.<br><br>R2's record lacked evidence of the following:<br>- bed rail assessment for current bed rail in use<br>- documentation of a risk versus benefits discussion<br>- manufacturer instructions for the bed rail<br>- evidence the bed rail was installed, used, and maintained per manufacturer's guidelines<br>- evidence of checking the Consumer Product Safety Commission (CPSC) for recalls<br><br>On January 13, 2026, at 9:44 a.m., clinical nurse supervisor (CNS)-B reviewed R2's bed rail documents and stated she thought R2 had previously used a halo bed rail; however, was not sure as she was not working for the licensee at that time. CNS-B stated the licensee's process was that the nurse completed the assessments and required documentation for all bed rails and the maintenance staff installed bed rails. CNS-B stated R2's record lacked the required documentation for R2's current bed rail in use.<br><br>The licensee's Bed Rails and Bed Assistive Devices policy dated January 2025, indicated the following:<br>- a licensed nurse would assess the appropriateness and safety of bed rail or bed assist device use when the device may impact resident safety. Findings are documented in the | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 34<br><br>service plan<br>-resident consent or representative consent is obtained prior to initiating bed rail or bed assist device use. Consent and resident preferences are documented in the care or service plan<br>-when a bed rail or bed assist device is used, the care or service plan reflects: the purpose of the device, identified risk and mitigation strategies and monitoring expectations<br>-documentation related to bed rail or bed assist device use includes assessment findings, consent, care or service plan integration, and monitoring outcomes<br><br>The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe".<br><br>The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without | 02310 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 21583 | A. BUILDING: _____ B. WING _____ | 01/14/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WALKER METHODIST RIVER HEIGHTS | 744 19TH AVENUE NORTH S ST PAUL, MN 55075 |

| (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 |
|---|---|---|---|---|
| 02310 | Continued From page 35<br><br>assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to:<br>- Purpose and intention of the bed rail;<br>- Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;<br>- The resident's bed rail use/need assessment;<br>- Risk vs. benefits discussion (individualized to each resident's risks);<br>- The resident's preferences;<br>- Installation and use according to manufacturer's guidelines;<br>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and<br>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE<br><br>On January 13, 2026, the licensee implemented actions to mitigate the risk to R2. Scope and severity remain at G. | 02310 | | |

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 RIVER HEIGHTS
744 19TH AVENUE NORTH
South St Paul, MN 55075
Dakota County
Parcel:

Phone:

## License Info

License: HFID 21583

Risk:
License:
Expires on:
CFPM: Nicole Melin
CFPM #: FM62725; Exp: 5/12/2027

## Inspection Info

Report Number: F1004261010
Inspection Type: Full - Single
Date: 1/12/2026 Time: 11:30:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 3
Total Priority 2 Orders: 0
Total Priority 3 Orders: 6
Delivery: Emailed

! **New Order: 2-200 Employee Health**
2-201.11C *Priority Level: Priority 1 CFP#: 3*
*MN Rule 4626.0040C* The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.
COMMENT: **NO EMPLOYEE ILLNESS LOG UTILIZED BY THE ESTABLISHMENT. ENSURE ALL EMPLOYEE REPORTS OF VOMITING, DIARRHEA, OTHER ACUTE GASTROINTESTINAL ILLNESS, OR ILLNESS/SYMPTOMS THAT CAN BE FOODBORNE ARE RECORDED ON AN EMPLOYEE ILLNESS LOG, AND PROVIDED TO THE REGULATORY AUTHORITY WHEN REQUESTED. *ILLNESS LOG PROVIDED WITH REPORT.**
*Comply By: 1/12/2026 Originally Issued On: 1/12/2026*

**New Order: 3-300C Protection from Contamination: equipment/utensils, consumers**
3-304.14B *Priority Level: Priority 3 CFP#: 41*
*MN Rule 4626.0285B* Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
COMMENT: **WIPING CLOTH BUCKETS FOUND WITH A QUATERNARY AMMONIUM CONCENTRATION OF 0PPM. ENSURE WIPING CLOTHS ARE MAINTAINED IN AN APPROVED CONCENTRATION OF SANITIZER TO PREVENT BACTERIAL GROWTH (200-400PPM FOR QUATERNARY AMMONIUM).**
***ESTABLISHMENT WILL HAND-MIX SANITIZER SOLUTION UNTIL DISPENSER IS REPAIRED/ADJUSTED.**
*Comply By: 1/12/2026 Originally Issued On: 1/12/2026*

! **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: **FOOD ITEMS IN THE MEMORY CARE REFRIGERATOR MEASURED BETWEEN 46-47*F. ENSURE ALL COLD, TCS FOOD ITEMS ARE MAINTAINED AT OR BELOW 41*F. *ALL TCS ITEMS, INCLUDING MILK AND YOGURT, WERE DISCARDED ON SITE.**
*Comply By: 1/12/2026 Originally Issued On: 1/12/2026*

! **New Order: 3-800 Highly Susceptible Population**
3-801.11B *Priority Level: Priority 1 CFP#: 26*
*MN Rule 4626.0447B* Discontinue using unpasteuerized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.
COMMENT: **FULL CODE REFERENCE: 4626.0447B Pasteurized eggs or egg products must be substituted for raw eggs in the preparation of:**
**(1)foods such as Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages; and**
**(2)except as specified in item F, recipes in which more than 1 egg is broken and the eggs are combined.**

**F.Item B, subitem (2), does not apply if:**
**(1)the raw eggs are combined immediately before cooking for one consumer's serving at a single meal, cooked as specified in part 4626.0340, item A, subitem (1), and served immediately, such as an omelet, souffle, or scrambled eggs;**
**(2)the raw eggs are combined as an ingredient immediately before baking and the eggs are thoroughly cooked to a ready-to-eat form, such as a cake, muffin, or bread.**

**POOLED, UNPASTERIZED EGGS FOUND IN THE ATOSA COOLER. DISCONTINUE POOLING UNPASTERIZED EGGS FOR SERVICE OF A HIGHLY SUSCEPTIBLE POPULATION UNLESS FOR IMMEDIATE SERVICE OF A SINGLE CONSUMER, OR FOR IMMEDIATE BAKING. *INFORMATION PROVIDED WITH REPORT.**
*Comply By: 1/12/2026 Originally Issued On: 1/12/2026*

**New Order: 4-400 Equipment Location and Installation**
4-402.11A *Priority Level: Priority 3 CFP#: 47*
*MN Rule 4626.0725A* Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.
COMMENT: **DISH LINE IS NO LONGER SEALED TO THE WALL. RESEAL TO PREVENT BACKSPLASH AND DEBRIS FROM ACCUMULATING BETWEEN EQUIPMENT AND WALL SPACE.**
*Comply By: 1/19/2026 Originally Issued On: 1/12/2026*

**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: **SANITIZER DISPENSER FOR THE WIPING CLOTH BUCKETS IS NOT DISPENSING A MEASURABLE CONCENTRATION OF QUATERNARY AMMONIUM. HAVE UNIT SERVICED AND MAINTAIN. *SERVICING COMPANY HAS BEEN CONTACTED.**

**REFRIGERATOR IN THE MEMORY CARE KITCHEN IS UNABLE TO MAINTAIN FOOD TEMPERATURES OF 41*F OR BELOW. HAVE UNIT REPAIRED/ADJUSTED/REPLACED AND MAINTAIN.**
*Comply By: 1/12/2026 Originally Issued On: 1/12/2026*

**New Order: 4-600 Cleaning Equipment and Utensils**
4-601.11C *Priority Level: Priority 3 CFP#: 49*
*MN Rule 4626.0840C* Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: **(ORIGINALLY ISSUED 4/14/23):**
**THE SAFETY GUARD OF THE COMMERCIAL MIXER CONTAINS AN ACCUMULATION OF DRIED BATTER SPLATTER. CLEAN AND SANITIZE AFTER EACH USE.**

**THE FLOOR OF THE WALK-IN FREEZER CONTAINS DRIED FOOD DEBRIS AND SPILLAGE UNDER THE STORAGE SHELVES. CLEAN AND MAINTAIN CLEAN.**
**REISSUED 1/12/26.**
*Comply By: 4/14/2023 Originally Issued On: 1/12/2026*

**New Order: 6-300 Physical Facility Numbers and Capacities**
6-301.14A *Priority Level: Priority 3 CFP#: 10*
*MN Rule 4626.1457* Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: **(ORIGINALLY ISSUED 4/14/23):**
**ONE OF THE HANDWASHING SINKS IN THE MEMORY CARE KITCHEN IS MISSING A HANDWASHING SIGN/POSTER. PROVIDE AND MAINTAIN. REISSUED 1/12/26.**
*Comply By: 4/14/2023 Originally Issued On: 1/12/2026*

**New Order: 8-500A Embargo/Condemnation**
8-501.03MN *Priority Level: Priority 3 CFP#: 58*
*MN Rule 4626.1810* The following items are condemned and shall be removed from the establishment immediately:
COMMENT: **TEMPERATURE ABUSED TCS ITEMS IN THE MEMORY CARE REFRIGERATOR, INCLUDING MILK AND YOGURT.**
*Comply By: 1/12/2026 Originally Issued On: 1/12/2026*

## Food & Beverage General Comment

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

DISCUSSED:
-EMPLOYEE ILLNESS POLICY AND LOG
-HANDWASHING
-SANITIZER USE AND TEST KITS
-CLEANING/SANITIZING FOOD CONTACT SURFACES AND UTENSILS
-HIGH TEMPERATURE SANITIZING DISH MACHINE TEMPERATURE VERIFICATION
-DATE MARKING PROCEDURES
-THERMOMETER USE AND CALIBRATION
-SERVING A HIGHLY SUSCEPTIBLE POPULATION (NO RAW/UNDERCOOKED ANIMAL FOODS, NO UNPASTEURIZED JUICE, MILK, ETC)
-VOMIT/FECAL INCIDENT CLEAN UP PROCEDURES (CULINARY STAFF ARE NOT RESPONSIBLE FOR INCIDENT CLEAN UP)
-FOOD SOURCE
-RECEIVING DELIVERIES PROCEDURES
-FOOD SERVICE PROCEDURES
-PEST CONTROL
-PHYSICAL FACILITIES AND MAINTENANCE

*REPORT WAS DISCUSSED WITH THE EXECUTIVE DIRECTOR, BLAKE, AND WITH THE NURSE EVALUATOR, KASSIE.

*MEMORY CARE UNIT CONTAINS A SMALL SERVICING KITCHEN. NO FOOD PREPARATION OR PLATING IS DONE IN THE MEMORY CARE KITCHEN.

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

***INSPECTOR WILL RETURN FOR A FOLLOW-UP INSPECTION***

**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 F1004261010 from 1/12/2026**

Molly Dougherty

Blake Dehnke
Executive Director

Molly Dougherty,
Public Health Sanitarian 3
651-201-3978
molly.dougherty@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 RIVER HEIGHTS
South St Paul
County/Group: Dakota County

## Inspection Info

Report Number: F1004261010
Inspection Type: Full
Date: 1/12/2026
Time: 11:30:00 AM

**Food Temperature: Product/Item/Unit:** milk**; Temperature Process:** Cold-Holding
**Location:** Memory Care Refrigerator at 47 Degrees F.
Comment: *discarded on site
*Violation Issued?: Yes*

**Equipment Temperature: Product/Item/Unit:** ambient temperature**; Temperature Process:** Cold-Holding
**Location:** Memory Care Refrigerator at 46 Degrees F.
Comment: *all TCS items discarded on site.
*Violation Issued?: Yes*

**Food Temperature: Product/Item/Unit:** ham**; Temperature Process:** Cold-Holding
**Location:** Prep Cooler at 40 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** sliced tomato**; Temperature Process:** Cold-Holding
**Location:** Prep Cooler at 40 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** turkey**; Temperature Process:** Cold-Holding
**Location:** Prep Cooler at 39 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** beef**; Temperature Process:** Hot-Holding
**Location:** Steam Table at 203 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** rice**; Temperature Process:** Hot-Holding
**Location:** Steam Table at 197 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** milk**; Temperature Process:** Cold-Holding
**Location:** True Refrigerator at 40 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** mashed potato**; Temperature Process:** Cold-Holding
**Location:** Atosa Refrigerator at 38 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** cut melon**; Temperature Process:** Cold-Holding
**Location:** Atosa Refrigerator at 38 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** soup**; Temperature Process:** Hot-Holding
**Location:** Soup Well at 156 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** butter**; Temperature Process:** Cold-Holding
**Location:** Walk-in Cooler at 40 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** cut lettuce**; Temperature Process:** Cold-Holding
**Location:** Walk-in Cooler at 40 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 RIVER HEIGHTS
South St Paul
County/Group: Dakota County

## Inspection Info

Report Number: F1004261010
Inspection Type: Full
Date: 1/12/2026
Time: 11:30:00 AM

**Sanitizing Chemical**: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
**Location:** Expo Line **Equal To** 0 PPM
Comment:
*Violation Issued?: Yes*

**Sanitizing Chemical**: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
**Location:** Cook Line **Equal To** 0 PPM
Comment:
*Violation Issued?: Yes*

**Sanitizing Equipment**: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
**Location:** Dishwashing Area **Equal To** 175 Degrees F.
Comment: *utensil surface temperature
*Violation Issued?: No*

DEPARTMENT OF HEALTH

# Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

| | |
|---|---|
| **Project No:** SL21583016 | **Date:** 1/13/2026 |
| **Facility Name:** Walker Methodist River Heights | |
| **Facility Address:** 744 19th Ave. South St. Paul | |

☒ **TAG IDENTIFICATION: 0775**

**SCOPE/ SEVERITY:** Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2] Where onehour fire-resistive-rated construction is required by IFC Chapter 11, as amended, it includes equivalent ratings for openings in that construction. When openings are required to be protected, opening protectives shall be maintained self-closing or automatic-closing by smoke detection. Existing fusible-link-type automatic door-closing devices are permitted if the fusible link rating does not exceed 135°F (57°C). [Minn. Stat. 144G.45 subd. 2; MSFC 1103.4.1]

   *Comments: The trash chute in the basement was held open with a wooden wedge. The fusible link and chain were missing from the door.*

2. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   *Comments: The emergency exit door, in the memory care unit, that lead out to a patio, did not have the snow removed so that there was a clear pathway leading to a public way.*

3. Controlled egress doors shall: unlock upon activation of either the automatic sprinkler system or smoke detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked by a signal or switch from the fire command center, nursing station, or other approved location. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   *Comments: The emergency exit doors leading outside had a keypad that required a code to unlock the doors. When interviewed about the controlled egress locking system, environmental service manager (ESM)-I stated that there was no manual override for the controlled egress locks in the memory care unit.*