Electronically Delivered

September 16, 2025

Licensee
Folkestone
100 Promenade Avenue
Wayzata, MN 55391

RE: Project Number(s) SL29889016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 18, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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

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

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

The correction order documentation should include the following:

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

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

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

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with Folkestone. **Please contact Kelly Thorson at 320-223-7336 on or before Friday September 19, 2025, to schedule the conference call.**

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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29889	A. BUILDING: _____ B. WING _____	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE	100 PROMENADE AVENUE WAYZATA, MN 55391

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0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL29889016-0 On July 15, 2025, through July 18, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 74 residents; all of whom were receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 100 SS=F	144G.10 Subdivision 1 License required	0 100		

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0 100	Continued From page 1 (a)(1) Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.	0 100		

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0 100	Continued From page 2 (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to manage, control, and/or operate the entire building as an assisted living facility. The building contained two different health care facility licensed spaces as well as retail space. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 14, 2025, from approximately 11:40 a.m., until 2:00 p.m., the engineer evaluator (EE) toured the facility with licensed assisted living	0 100		

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0 100	Continued From page 3 director (LALD)-C, maintenance (M)-A, regional maintenance (RM)-F and administrator (A)-G. The EE also reviewed architectural documents provided by LALD-C, M-A and A-G. The building was found to roughly resemble the shape of a capital letter "I" with a 2-hour fire wall dividing the building in half into a north half and a south half. The first, second, third, and fifth floors were being used as unlicensed apartment space on the north half of the building. The south half of the building contained the secured dementia care unit, a storage area, and retail space on first floor. The retail space was open to the public and the licensee's building contained resident living space directly above the retail space. The second and third floor on the south half of the building contained assisted living space. The fourth floor is being used as another licensed space, "long-term care" (skilled nursing facility). A-G and LALD-C stated that the entire fourth floor has long term care on both sides of the fire wall. The area on the fifth floor south of the two-hour fire wall is again used as "assisted living" space. Record review of a facility map indicated that the north half of the fourth floor has "independent living", however A-G and LALD-C stated this is not the current use. The EE requested records from the facility regarding horizontal separations between the skilled nursing home floor from assisted living licensed floors and the licensee was unable to provide it. The facility map further indicated one unit, number 319, labeled as "independent living". This unit is indeed located on the south side of the two-hour fire wall, inside the assisted living facility, and was verified by the EE. The EE said	0 100		

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0 100	Continued From page 4 the unit was occupied. During the entrance conference on July 15, 2025, at 9:50 a.m., LALD-C stated the licensee had a current census of 74 residents, all of whom were receiving services. LALD-C stated, "We have no "IL" residents under this license they live in the Terrace building and that is separate from this building, so they do not count in our numbers." The licensee's Application for Assisted Living License signed November 5, 2024, identified an application for an assisted living with dementia care license with a total licensed resident capacity for 90 residents. Unit 319 was not included in the assisted living resident roster provided to survey staff by LALD-C. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 100		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and	0 480		

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0 480	Continued From page 5 supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.	0 480		

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0 480	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 15, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 775		

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0 775	Continued From page 7 failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 14, 2025, from approximately 11:40 a.m. to 3:20 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-C, maintenance (M)-A, regional maintenance (RM)-F and administrator (A)-G. During the tour, the surveyor observed the following deficient conditions: Sprinkler heads were obstructed by high piled storage in closets in resident room 324, resident room 329, resident room 222, and kitchen storage area on the first floor near loading dock. Proper clearance should be provided and maintained around sprinkler heads to ensure proper operation. The trash chute door on the second-floor trash chute would not pull closed completely when tested. The trash chute door should function properly and self-close fully. Trash chute doors are components of vertical opening protections and should be maintained in working order.	0 775		

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0 775	Continued From page 8 The discharge door of the trash chute located in the trash room on the first floor near the loading dock was held open by a piece of metal that had been screwed onto the assembly. The discharge door should be equipped with a proper fusible link that pulls the door closed upon detection of heat to close the trash chute and prevent the spread of smoke or flame. M-A confirmed that the assemble had been equipped with a fusible link, but roughly two weeks before the survey that the fusible link was removed and replaced with an unrated piece of metal. Fire safety equipment such as the fusible link should be maintained, and the discharge door should be equipped with a fusible link so that it may close in event of fire emergency. The fire rating placard on the fire door that is part of the fire wall, separating North and South sections of the facility was painted over on the fifth floor. The fire rating placard should be maintained visible and legible to verify rating of the fire wall component. Multiplug adapters were in use in resident room resident room 529, resident room 327, resident room 329, and resident room 222. The supplied multiplug adapters are not rated for continuous use and may pose a fire risk. M-A acknowledged the use of the multiplug adapters and indicated that they would conduct further training with residents to avoid use of such devices. Fire doors were propped open on the general storage area near the loading dock, and the pool chemical storage room near the building sprinkler riser room. Fire doors should be maintained free of obstruction to ensure that may close	0 775		

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0 775	Continued From page 9 appropriately upon activation of fire alarm system. During the facility tour interview on July 14, 2025, LALD-C, M-A, A-G and RM-F verified the above listed fire protection observations while accompanying on the tour. The surveyor explained to LALD-C, M-A, A-G and RM-F the requirements for fire protection equipment and they stated they understood requirements and would make appropriate changes. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation	01620		

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01620	Continued From page 10 of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing nursing assessments not to exceed every 90-days for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620		

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01620	Continued From page 11 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 admitted to the licensee and began receiving assisted living services on April 26, 2024. R3's diagnoses included dementia, heart failure, and gastroesophageal reflux disease (a digestive disorder where stomach acid flows back into the esophagus, causing symptoms of heartburn). R3's Service Plan signed January 30, 2025, indicated R3 received assistance with medication administration, laundry, linen changes, homemaking, showers and AM/PM standard assistance. R3's record included 90-day ongoing comprehensive assessments dated November 20, 2024, February 20, 2025, and June 5, 2025, indicating 92 days passed between R3's November and February assessment, and 105 days passed between R3's February and June assessment. On July 17, 2025, at 12:39 p.m., clinical nurse supervisor (CNS)-D acknowledged via email that there were no other assessments for R3 between February 20, 2025 and June 5, 2025. OnJuly 17, 2025, at 2:34 p.m., CNS-D stated, "Our assessments should be done every 90 days	01620		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE	100 PROMENADE AVENUE WAYZATA, MN 55391

(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
01620	Continued From page 12 or with a change of condition." The licensee's MN AL Nursing Assessment Policy, dated August 1, 2021, read, "Ongoing assessment: completed periodically but no less than every 90 days." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed by one of one unlicensed personnel (ULP-E) observed during medication administration for R2. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29889	A. BUILDING: _____ B. WING _____	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE	100 PROMENADE AVENUE WAYZATA, MN 55391

(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
01750	Continued From page 13 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted to the licensee and began receiving assisted living services on June 9, 2023. R2's diagnoses included dementia, major depressive disorder, kidney failure, and hypertension. R2's service plan, dated December 26, 2024, indicated R2 received services for medication administration. R2's prescriber orders included potassium chloride 20 milliequivalent extended release (MEQ ER). On July 16, 2025, at 9:25 a.m., ULP-E set up medication for R2 by punching out of packets into a medication cup, R2's medications included potassium. ULP-E placed the medications, including the potassium into the pill crusher and surveyor intervened before ULP-E could crush the medications. ULP-E was asked where the instructions stated to crush the medications. ULP-E stated, "We crush her meds because that's the only way she can take her meds, so we crush them every day." ULP-E went to ask the nurse for clarification and came back and removed the potassium and crushed the rest of the medications and slurries the potassium and administered the medications.	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29889	A. BUILDING: _____ B. WING _____	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE	100 PROMENADE AVENUE WAYZATA, MN 55391

(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
01750	Continued From page 14 R2's record lacked resident specific instruction to crush or slurry specific medication on the medication administration record (MAR). On July 16, 2025, at 2:30 p.m., clinical nurse supervisor (CNS)-D acknowledged that R2 did not have instructions to crush medications in her chart and CNS-D stated, "All the charts should have specific instructions in them if there is a need and the staff should not be crushing medications without being instructed to do so, we have it put into [R2's] chart now. We did talk with the pharmacy, and they are having us change the type of potassium pills she gets so it can be crushed." The licensee's AL Administration of Medication by Resident Assistants Policy, dated August 1, 2021, read, "The RN may delegate to resident assistants the task of providing assistance with self administration of medications or may delegate administration of me dications if the resident assistants have satisfied the training requirements listed above and if: a. Before performing the procedures, the RN has instructed the resident assistants in the proper methods to administer the medications and the resident assistan ts have demonstrated the ability to competently follow the procedures; b. The RN has developed written, specific instruction for each resident; c. The RN has communicated with the resident assistants about the individual needs of the resident; and d. The RN has do cumented that the resident assistants have been trained and have demonstrated competency to follow the procedures."	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29889	A. BUILDING: _____ B. WING _____	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOLKESTONE	100 PROMENADE AVENUE WAYZATA, MN 55391

(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
01750	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

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

Folkestone
100 Promenade Ave
Wayzata, MN 55391
Hennepin County
Parcel:

Phone:

License Info

License: HFID 29889

Risk:
License:
Expires on:
CFPM: Mary Elizabeth Jacobson
CFPM #: 15007; Exp: 4/28/2028

Inspection Info

Report Number: F7994251059
Inspection Type: Full - Single
Date: 7/15/2025 Time: 11:24:41 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.12D *Priority Level: Priority 3 CFP#: 43*
MN Rule 4626.0275D Store food preparation or dispensing utensils in running water of sufficient velocity to flush particles to the drain.
COMMENT: ICE CREAM SCOOPS FOUND STORED IN STANDING WATER. FACILITY HAS ORDERED A HOT HOLDING CONTAINER FOR SCOOPS.
Comply By: 7/22/2025 Originally Issued On: 7/15/2025

New Order: 4-100 Equipment Construction Materials
4-101.11BCDE *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.
COMMENT: KNIFE IN SATELLITE KITCHEN FOUND WITH BADLY DAMAGED HANDLE THAT IS NO LONGER ABLE TO BE CLEANED. REPLACE KNIFE WITH AN APPROVED KNIFE.
Comply By: 7/22/2025 Originally Issued On: 7/15/2025

! **New Order: 5-200B Plumbing: cross connections**
5-203.14I *Priority Level: Priority 1 CFP#: 51*
MN Rule 4626.1085A Remove the control valve located on the discharge side of the atmospheric vacuum breaker backflow prevention device.
COMMENT: Y ADAPTOR FOUND ON MOP SINK FAUCET AS WELL AS A NON WORKING ATMOSPHERIC VACUUM BREAKER. REMOVE Y ADAPTOR AND REPAIR ABV.
Comply By: 7/15/2025 Originally Issued On: 7/15/2025

! **New Order: 8-100 HACCP/Variance Conformance**
8-103.12B *Priority Level: Priority 1 CFP#: 29*
MN Rule 4626.1700B Comply with the HACCP plan and procedures that are submitted to, and approved by, the regulatory authority for the variance granted. Maintain records as specified in the rule.
COMMENT: REDUCED OXYGEN PACKAGED CHILI FOUND 12 DAYS OUT OF DATE IN THE COOLER. ENSURE INSTRUCTIONS FROM COMMISSARY KITCHEN ARE FOLLOWED AND ANY MONITORING THAT IS REQUIRED IS ALSO DONE. STAFF DISCARDED OUT OF DATE ITEMS.
Comply By: 7/15/2025 Originally Issued On: 7/15/2025

Food & Beverage General Comment

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

TEMPERATURES:
LINE COOLER -
TOMATOES 38
LETTUCE 40
TURKEY 38

HOT HOLDING
RICE 158
BEEF 157

COOK TEMP
BURGER 176

EXPO AREA
SOUP 176

SATELLITE KITCHEN
RICE 178
BEEF 169

SANITIZERS:
DISHWASHER 176 F

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 F7994251059 from 7/15/2025

Jerry Miller
Executive Chef

Crystal Elva, REHS, MS, BS
Public Health Sanitarian 3
651-201-3981
crystal.elva@state.mn.us

Minnesota (MDH) Version
EH Manager; RPT: F7994251059

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	0	Date: 7/15/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:24:41 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Folkestone	100 Promenade Ave	Wayzata, MN	55391	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 29889		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

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

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

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
	Safe Food and Water			
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	IN	Variance obtained for specialized processing methods		
	Food Temperature Control			
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
	Food Identification			
37		Food properly labeled; original container		
	Prevention of Food Contamination			
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
	Proper Use of Utensils			
43	X	In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
	Utensils, Equipment and Vending			
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
	Physical Facilities			
50		Hot & cold water available; adequate pressure		
51	X	Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Crystal Elva

Follow-up: Follow-up Date: