DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

April 3, 2023

Licensee
Autumn Glen Senior Living
3715 Coon Rapids Boulevard Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL31129015

Dear Licensee:

On March 16, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the January 25, 2023, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 218-332-5175 Fax: 651-281-9796

JMD

Electronically Delivered
February 13, 2023

Licensee
Autumn Glen Senior Living
3715 Coon Rapids Boulevard Northwest
Coon Rapids, MN 55433

RE: Project Number(s) SL31129015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 25, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $6,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter

as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

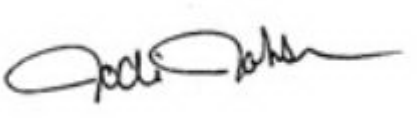
REQUESTING A HEARING

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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31129	A. BUILDING: _____ B. WING _____	01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN GLEN SENIOR LIVING	3715 COON RAPIDS BOULEVARD NW COON RAPIDS, MN 55433

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL31129015 On January 23, 2023, through January 25, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 89 active residents; 58 of whome were receiving services under the Assisted Living with Dementia Care license. The immediacy of correction order, tag identification 2070 and 2310 was removed January 24, 2023, scope and level of noncompliance remained at level 3, widespread (I).	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510		

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0 510	Continued From page 1 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for hand hygiene for one of three employees (unlicensed personnel (ULP-J). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On January 24, 2023, at 7:15 a.m. the evaluator observed ULP-J apply gloves and assist R2 with incontinent pull up removal. Without removing soiled gloves and performing hand hygiene, ULP-J placed a clean incontinent pull up, dressed R2's lower body, removed R2's shirt, washed,	0 510		

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0 510	Continued From page 2 dried and dressed R2's upper body, provided peri (perineal) care, and wiped R2 from front to back; however, ULP-J used the same area of wash cloth with each swipe, and removed gloves. Without performing hand hygiene, ULP-J applied gloves, completed dressing R2 by raising all clothing items on lower extremities, assisted with oral cares, groomed R2's hair, removed gloves, and performed hand hygiene. On January 24, 2023, at 7:35 a.m. the evaluator observed ULP-J perform blood glucose monitoring on R2 and remove gloves. Without performing hand hygiene, ULP-J applied gloves, removed test strip from the glucometer, prepared 10 units of Lantus, administered an eye drop to R2, collected trash, and removed gloves. Without performing hand hygiene, ULP-J removed the trash bag from R2's room to the hallway, re-entered the apartment, and performed hand hygiene. On January 24, 2023, at 12:09 p.m. registered nurse (RN)-B stated staff completed Relias (a training software program) training on infection control and hand hygiene upon hire. In addition, RN-B stated staff were trained to perform hand hygiene with toileting, when gloves were applied and removed, and before and after cares. On January 25, 2023, at 8:21 a.m. ULP-J stated they were trained to perform hand hygiene with cares, during toileting, after perineal care was performed, and with glove removal. The Center of Disease Control (CDC) Morbidity and Mortality Weekly Report (MMWR) Guidelines for Hand Hygiene in Health-Care Settings dated October 25, 2022, recommend hand hygiene to be completed before direct contact with patient	0 510		

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0 510	Continued From page 3 [residents], moving from a contaminated-body site to a clean-body site during care, and after removing gloves. The licensee's Infection Control policy dated August 1, 2021, indicated the licensee's infection control program would be consistent with current guidelines from the CDC. The licensee's Gloves policy dated August 1, 2021, indicated hand hygiene would be performed after glove removal. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced	0 660		

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0 660	Continued From page 4 by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) including documentation of completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of three employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's TB risk assessment dated August 31, 2022, indicated the licensee was a low risk. ULP-D's employee record showed ULP-D had a start date of June 14, 2022. ULP-D's employee's record contained a chest x-ray dated June 25, 2021 (354 days prior). On January 25, 2023, at 8:35 a.m. regional director of health care services (RDHCS)-K confirmed ULP-D's employee file did not include evidence of TB testing upon hire. The Minnesota Department of Health, Regulations for Tuberculosis Control in Health	0 660		

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0 660	Continued From page 5 Care Settings dated July 2013, indicated: Baseline TB screening is required for all HCWs (Table 3.1). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA (Interferon Gamma Release Assay - a blood test used to see whether a person has been infected with the bacteria causing TB). The 2-step TST identified as: Procedure used for the baseline skin testing of persons who will receive serial TSTs (e.g., HCWs and residents of long term-care facilities) to reduce the likelihood of mistaking a boosted reaction for a new infection. If an initial TST result is classified as negative, a second step of a two-step TST should be administered 1-3 weeks after the first TST result was read. If the second TST result is positive, it probably represents a boosted reaction, indicating infection most likely occurred in the past and not recently. If the second TST result is also negative, the person is classified as not infected. The licensee's 8.16 Tuberculosis Screening policy dated August 1, 2021, indicated new staff will have an IGRA blood test or a two-step Mantoux conducted with result documented on Baseline TB Screening Tool for HCWs (health care workers). No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented.	0 660		

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0 660	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 800		

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0 800	Continued From page 7 On a facility tour on January 24, 2023, at approximately 11:15 a.m. with director of maintenance (DM)-G, regional operations director (RDO)-H and director (LALD)-A, the marked exit door was observed with a keyed lock to control use of the door in the direction of egress travel leading from the common main floor corridor near the dementia care unit interior entrance. This door leads through a corridor in the commercial kitchen area to a marked exterior exit. These marked exit doors are required to be available for immediate use for exiting at all times as designed. On the same facility tour, storage items were observed in the means of egress corridor in the marked exit corridor leading from the common main floor corridor near the dementia care unit interior entrance. This corridor leads through the commercial kitchen area to a marked exterior exit. Keeping this required means of egress clear of obstructions helps provide access to the exits for occupants during an emergency. It was observed that the furnace in the second-floor community room was leaking condensate drainage onto the floor and not draining into the drain as provided and designed. This deficient condition was visually verified by DM-G accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 8 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to provide required employee and resident training on fire safety and evacuation plan. This had the potential to affect all staff, residents, and visitors.	0 810		

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0 810	Continued From page 9 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). A record review and interview were conducted on January 24, 2023, at approximately 10:30 a.m. of documents provided by director of maintenance (DM)-G, regional operations director (RDO)-H and director (LALD)-A, on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Findings include: Record review of the available documentation indicated that the licensee did not maintain the fire safety and evacuation plan for the facility as follows: Record review of the available documentation indicated that employees did not receive training on the facility fire safety and evacuation plan upon initial hire and twice per year thereafter. Record review of the available documentation indicated that the licensee did not provide training at least once per year to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire regarding movement, evacuation, and relocation. All deficiencies were verified by DM-G, RDO-H and LALD-A during the interview at approximately	0 810		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 10 10:45 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the 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. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (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 (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. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case	01060		

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01060	Continued From page 11 manager; and (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. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3's Service Plan dated May 14, 2022, indicated R3 received services to include a.m. and p.m. cares, bathing assistance, safety check, escort, laundry, toileting, and medication administration. R3's progress notes printed January 24, 2023, indicated R3 had an emergency relocation to the hospital due to a fall with suspected head injury	01060		

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01060	Continued From page 12 from November 14, 2022, through November 18, 2022. R3's record lacked a written notice with the required statutory content provided to resident, resident representative or to the OOLTC within four days of emergency relocation. On January 24, 2023, at 10:25 a.m. regional director of healthcare services (RDHCS)-K verified the required statutory content was not given to any residents for hospitalizations as they were "under the impression that was only necessary if there was an emergency like safety or behavior and we [licensee] need to relocate them [residents] for that reason." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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	01620		

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01620	Continued From page 13 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. (e) 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 observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted a reassessment, not to exceed 14 calendar days after the initiation of services for one of four residents (R2) and failed to ensure the RN conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of four residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: 14-DAY R2 began receiving assisted living services on May 5, 2022.	01620		

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01620	Continued From page 14 R2's diagnoses included Alzheimer's disease, type 2 diabetes mellitus (DM2), macular degeneration, urge incontinence, hypertension (HTN), and edema. R2's Service Plan Agreement signed October 21, 2022, indicated R2 received assistance with toileting, dressing, grooming, oral care, compression wraps, bathing, blood glucose monitoring, laundry, escort, safety checks, and medication management. On January 24, 2023, at 7:35 a.m. the evaluator observed unlicensed personnel (ULP)-J administer morning medications to R2. R2's record included a 14 - day assessment titled MN Comprehensive Nursing & Service Plan Evaluation signed May 26, 2022, (21 days after admission). 90-DAY R5 began receiving assisted living services on May 5, 2022. R5's diagnoses included cellulitis of the left lower limb, muscular dystrophy, peripheral vascular disease, and HTN. R5's Service Plan and Agreement signed January 2, 2023, indicated R5 received assistance with bathing, transfers, dressing, grooming, oral care, blood glucose monitoring, and medication assistance. On January 24, 2023, at 8:22 a.m. the evaluator observed ULP-L administer morning medications to R5.	01620		

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01620	Continued From page 15 R5's record included three 90-day re-assessments titled MN Comprehensive Nursing & Service Plan Evaluation signed June 3, 2022, September 9, 2022, and December 20, 2022, which indicated 98 days between the June and September assessments, and 102 days between the September and December assessments. On January 24, 2023, at 2:00 p.m. RN-B stated the assessments listed above were completed on time; however, RN-B did not lock them on time. The evaluator inquired how a person would be able to tell which date each section of an assessment was completed. RN-B stated, "you would not be able to tell, you would just have to go off the locked date [indicating the signed date on the form]." RN-B further stated, "I am the only full time RN, and we have an LPN [licensed practical nurse]. Sometimes the assessments got behind." The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2021, indicated resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services and ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 16 (a) For each resident receiving medication management services, the assisted living facility 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: (1) a statement describing the medication management services that will be provided; (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; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed	01730		

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01730	Continued From page 17 when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of four residents (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 began receiving assisted living services on May 5, 2022. R5's diagnoses included cellulitis of the left lower limb, muscular dystrophy, peripheral vascular disease, and hypertension. R5's Service Plan and Agreement signed January 2, 2023, indicated R5 received assistance with bathing, transfers, dressing, grooming, oral care, blood glucose monitoring, and medication assistance. R5's Physician Order Sheet dated December 19, 2022, included acetaminophen (pain reliever) 500 milligrams (mg), aspirin (anticoagulant) enteric	01730		

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01730	Continued From page 18 (EC) 81 mg, furosemide (diuretic) 20 mg, Genteal Tears (dry eye solution) eye drop, loratadine (anithystamine) 10 mg, metformin (diabetic) 500 mg, simvastatin (decreases cholesterol) 20 mg, and tamsulosin (decreases symptoms of prostate enlargement) 0.4 mg. R5's provider order signed January 19, 2023, included fexofenadine (seasonal allergies) 180 mg. R5's Medication Assistance Record dated January 1, 2023, through January 31, 2023, indicated the following medications were administered to R2 by the licensee's staff: aspirin EC 81 mg, fexofenadine 180 mg, furosemide 20 mg, loratadine 10 mg, metformin 500 mg, tamulosin 0.4 mg, and simvastatin 20 mg. On January 24, 2023, at 8:22 a.m. the evaluator observed ULP-L administer morning medications to R5. R5's individualized medication management plan lacked the content to include: - description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; and - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. The licensee provided the evaluator with a document titled Medication Assessment and	01730		

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01730	Continued From page 19 Management Plan signed on January 24, 2023. The document contained the required content for the individualized medication management plan; however, it was completed during the survey. On January 24, 2023, at 2:00 p.m. registered nurse (RN)-B stated R5's individual medication management plan was completed prior to January 24, 2023; however, it was locked on January 24, 2023. The evaluator inquired how a person would be able to tell which date each section of an assessment was completed on. RN-B stated, "you would not be able to tell, you would just have to go off the locked date [indicating the signed date on the form]." The licensee's Medication Management Individualized Plan dated August 1, 2021, indicated the individualized medication management record based on the resident's assessment must include the content listed above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the	01760		

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01760	Continued From page 20	01760		

reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.

This MN Requirement is not met as evidenced by:
Based on observation, interview, and record review, the licensee failed to ensure medications were administered per prescriber orders for two of eight residents (R3, R8).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

R3
R3's Service Plan and Agreement signed May 14, 2022, indicated R3 received services to include a.m. and p.m. cares, bathing assistance, safety check, escort, laundry, toileting, and medication administration.

R3's prescriber order dated July 20, 2022, included polyethylene glycol 3350 (Miralax) mix one capful (17 grams(g)) in liquid and take by mouth once daily.

R3's medication assistance record dated January 1, 2023, through January 31, 2023, included

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01760	Continued From page 21 polyethylene glycol 3350 (Miralax) mix one capful (17 g) in liquid and take by mouth once daily and indicated administration had been completed 23 times. On January 24, 2023, at 7:16 a.m. the evaluator observed unlicensed personnel (ULP)-C place an unmeasured amount of polyethylene glycol 3350 into the cap of the container, then proceed to mix the unmeasured amount into water. R8 R8's Service Plan and Agreement signed May 19, 2022, indicated R8 received services to include a.m. and p.m. cares, bathing assistance, safety check, laundry, toileting, and medication administration. R8's prescriber orders dated May 12, 2022, included diclofenac sodium 1 percent (%) gel apply topically to the right shoulder twice daily. R8's medication assistance record dated January 1, 2023, through January 31, 2023, included diclofenac sodium 1% gel apply topically to the right shoulder twice daily and indicated administration had been completed 47 times. On January 24, 2023, at 7:46 a.m. the evaluator observed ULP-C place an unmeasured amount of diclofenac gel 1% to the fingertips and applied the gel to R8's right shoulder. On January 24, 2023, at 8:11 a.m. ULP-C stated, "I just measure the gel with my hand. I know I have enough when he [R8] says I have rubbed enough on. I don't know if it's 4 grams or not. As for the amount of powder I am just adding a capful." ULP-C stated being unaware there were measurements located in the cap.	01760		

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01760	Continued From page 22 On January 24, 2023, at 2:05 p.m. registered nurse (RN)-B stated staff were competency trained and signed off by a RN to administer medications, which included training on how to measure powder medications and what tools to use for measuring cream or gel medications. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated August 1, 2021, indicated a RN must instruct the ULP on the preparation of medication and/or treatment/therapy for administration including to not alter medication via splitting, crushing, or having residents chew medication unless directed by the nurse or it is stated in the resident's medication administration instructions that it is safe to do so; and instructions on correct process for dosing powder or liquid medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included the	01770		

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01770	Continued From page 23 required content for one of one resident (R4). 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: During the entrance conference on January 23, 2023, at 11:05 a.m., registered nurse (RN)-B confirmed the licensee provided medication management services to the licensee's residents, including medication setup. R4's Service Plan and Agreement dated December 29, 2022, indicated R4 received weekly medication set-up by the licensed practical nurse (LPN) every Wednesday. On January 24, 2023, at 7:21 a.m. unlicensed personnel (ULP)-D was observed providing morning cares and administering medications to R4. R4's scheduled oral medications were observed to be previously set-up in a medi-minder, stored in a locked cabinet in the resident's apartment along with his other medications. ULP-D asked R4 if he would like his as needed Tylenol (pain reliever) along with his scheduled medications; the resident responded, "yes", and ULP-D administered R4's medications. R4's medication administration record (MAR) dated January 2023, did not include evidence of the medication set-up by the LPN.	01770		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01770	Continued From page 24 On January 24, 2023, at 2:57 p.m. LPN-I confirmed she only documented R4's medication set up had been completed each week. LPN-I further verified the documentation did not include the medication name, quantity of dose, times, or the route. LPN-I further confirmed this was the process for all medication set ups, and after reviewing the statute agreed the process needed to be changed. The licensee's 7.09 Medication Management - Dosage Box Setup dated August 1, 2021, indicated: 5. When the licensed nurse has completed setting up the medications into the dosage box, the set-up is documented on the MAR. No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy	01940		

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	31129	A. BUILDING: _____ B. WING _____	01/25/2023

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01940	Continued From page 25 administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a treatment management plan to include all required content for one of one resident (R2) with compression stockings. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2 began receiving assisted living services on May 5, 2022.	01940		

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01940	Continued From page 26 R2's Service Plan Agreement signed October 21, 2022, indicated R2 received assistance with toileting, dressing, grooming, oral care, compression wraps, bathing, blood glucose monitoring, laundry, escort, safety checks, and medication management. R2's prescriber order signed on July 14, 2022, included apply compression stockings in the morning and remove in the evening. R2's Service Checkoff List dated January 2023, indicated R2 received assistance with compression socks/wraps to be applied in the morning and removed in the evening. On January 24, 2023, at 7:15 a.m. the evaluator observed compression stocking on R2's lower legs. R2's treatment plan lacked the process for notifying a registered nurse (RN) or appropriate licensed health professional when an issue or concern arises. On January 24, 2023, at 12:16 p.m. RN-B stated the licensee did not use the document titled Treatment/Therapy Management Plan when a resident received compression stockings; however, components of the treatment plan would be located on the service plan and where the unlicensed professional (ULP) documented the treatment. The evaluator inquired if the licensee had included when to notify a licensed health professional if there was an issue with the compression therapy. RN-B stated the licensee's treatment plan lacked this component for all residents with compression stockings; however, it did include the component listed above for residents who received blood glucose monitoring.	01940		

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01940	Continued From page 27 The licensee's Treatment & Therapy Management Plan dated August 1, 2021, indicated the content listed above would be included in the individualized treatment and therapy management record for each resident receiving treatments or therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the facility was staffed 24 hours a day, seven days a week in the locked memory care unit. This had the potential to affect all residents residing at the facility and resulted in an immediate correction order on January 24, 2023, at 12:25 p.m. 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	02070		

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02070	Continued From page 28 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: The facility was licensed as an assisted living facility with dementia care. On January 23, 2023, at 11:05 a.m. during the entrance conference, registered nurse (RN)-B identified there were three staff working during the night shift, one for each secured memory care unit and one for the assisted living. RN-B confirmed there were residents in the assisted living outside of the memory care units who were a two-person assist. RN-B stated if they needed assistance during the night the staff would provide bedside care and utilize a bedpan for toileting. On January 24, 2023, at 6:54 a.m. unlicensed personnel (ULP)-E (night staff) confirmed having to sometimes leave the secured memory unit "just for falls". On January 24, 2023, at 7:05 a.m. ULP-F (night staff) stated if the assisted living staff was busy the second-floor memory care unit staff would call the staff on the first floor memory care unit for assistance. R6's incident reports for falls were reviewed and revealed the following: - Fall on October 9, 2022, at 12:35 a.m. Assisted x 2 up off the floor. - Fall on November 24, 2022, at 2:40 a.m. Assist x 2 to get up off the floor.	02070		

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02070	Continued From page 29 - Fall on January 20, 2023, at 1:25 a.m. Assist x 2 to get up off the floor. R7's incident reports for falls were reviewed and revealed the following: - Fall on January 13, 2023, at 1:14 a.m. Assist x 2 with transfer belt off the floor and into bed. The daily staffing schedules dated October 9, 2022, November 24, 2022, January 13, 2023, and January 20, 2023, were reviewed and revealed only three staff were scheduled for the night shift. On January 24, 2023, at 12:24 p.m. RN-B reviewed R6 and R7's fall incident reports from the overnight shift and confirmed only three staff were present in the building which would have left one of the memory care units unattended. RN-B stated, "I didn't know they were doing that". The licensee's Staffing and Scheduling policy dated August 1, 2021, indicated: 1. The clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. This plan is reviewed no less than twice per year. 2. The clinical nurse supervisor must ensure that staffing levels are adequate to address the following: a. Each resident's needs, as identified in the resident's service plan and assisted living contract. b. Each resident's acuity level, as determined by the most recent assessment or individualized review. c. The ability of staff to timely meet the residents' scheduled and reasonable foreseeable	02070		

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02070	Continued From page 30 unscheduled needs given the physical layout of the facility premises. d. Whether the facility has a secured dementia care unit, and e. Staff experience, training, and competency. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On January 24, 2023, the immediacy of correction order 2070 was removed; however, non-compliance remains at a scope and level of (I). TIME PERIOD FOR CORRECTION: Two (2) days	02070		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, medical or nursing standards for one of one resident (R4) with a bed rail. This resulted in an immediate correction order on January 24, 2023, at 12:55 p.m. This practice resulted in a level three violation (a	02310		

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02310	Continued From page 31 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 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: On January 23, 2023, at 7:20 a.m. unlicensed personnel (ULP)-D was observed performing cares and medication administration for R4. R4's bed was observed to have bilateral hospital rails on the bed in the down position. ULP-D stated she didn't think R4 ever used the bedrails. R4's diagnoses included transient cerebral ischemic attacks (a temporary period of symptoms similar to those of a stroke) and related syndromes, type two diabetes mellitus with diabetic neuropathy (a type of nerve damage that can occur if you have diabetes), and Parkinson's disease. R4's Service Plan dated, December 29, 2022, indicated R4 received services including medication administration, medication set-up, toileting assistance, laundry and escorts to and from meals. R4's change of condition assessment dated December 12, 2022, identified R4 required assistance with dressing and toileting, supervision with grooming, bathing, and mobility between locations, and independent with bed mobility. The assessment did not include the use of a bed rail.	02310		

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02310	Continued From page 32 R4's medical record did not include evidence of a bedrail assessment. On January 24, 2023, at approximately 10:00 a.m. the surveyor requested to see the bedrail assessment for R4. Registered nurse (RN)-B stated, "He doesn't have bedrails". The surveyor stated she had visualized them on R4's bed. RN-B stated she would "check into it." On January 24, 2023, at 10:47 a.m. RN-B confirmed R4 had bilateral hospital bed rails and stated the resident never uses them and that they are "zip-tied". RN-B confirmed they had just put the zip-ties on the bed rails today to ensure they couldn't be raised. RN-B stated they would do that because sometimes the families would think the rails should be up. RN-B confirmed she had no knowledge the rails existed until today. On January 24, 2023, at 12:38 p.m. R4 confirmed he does not use the bed rails and stated he received the bed from the VA (Veteran's Administration) shortly before moving in to the assisted living facility and then moved it here. R4 confirmed no one from the facility had approached him about the bedrails. The licensee's 6.28 Side Rail policy dated August 1, 2021, indicated: When the Assisted Living Facility is aware a home care resident is utilizing side rails (a medical device) on a bed, the facility will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail.	02310		

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02310	Continued From page 33 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On January 24, 2023, the immediacy of correction order 2310 was removed; however, non-compliance remains at a scope and level of (I). TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64975
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *01/23/23*
Time: 12:25:44
Report: 8058231017

Food and Beverage Establishment Inspection Report

Location:
Autumn Glen Senior Living
3715 Coon Rapids Boulevard Nw
Coon Rapids, MN55433
Anoka County, 02

Establishment Info:
ID #: 0039201
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7637724492
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: FRUIT CUP
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: TURKEY
Temperature: 176 Degrees Fahrenheit - Location: HOT WELL
Violation Issued: No

Process/Item: POTATOES
Temperature: 156 Degrees Fahrenheit - Location: HOT WELL
Violation Issued: No

Process/Item: TOMATO
Temperature: 41 Degrees Fahrenheit - Location: PREP
Violation Issued: No

Process/Item: HAM
Temperature: 37 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Process/Item: MELON
Temperature: 37 Degrees Fahrenheit - Location: WALK IN
Violation Issued: No

Type: Full
Date: *01/23/23*
Time: 12:25:44
Report: 8058231017
Autumn Glen Senior Living

Food and Beverage Establishment Inspection Report

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

COMMERCIAL FACILITY

HRD INSPECTOR: WENDY BUCKHOLZ

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8058231017 of 01/23/23.

Certified Food Protection Manager: CRAIG A CHARNOSKY

Certification Number: 12430 Expires: 05/06/23

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
Inspector Number 8058
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us