Electronically Delivered

April 11, 2022

Administrator
Midwest Homes Inc
1628 Keller Drive
Burnsville, MN 55306

RE: Project Number(s) SL35647015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 16, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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, no immediate fines are assessed.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35647	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MIDWEST HOMES INC	1628 KELLER DRIVE BURNSVILLE, MN 55306

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING 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: SL#35647015 On March 15, through March 16, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five (5) residents, all of whom recieved servcies under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 15, 2022, at approximately 10:00 a.m., owner (O)-C identified LALD-D as LALD for licensee. LALD-D obtained an assisted living director license on July 30, 2021. On March 16, 2022, at 12:51 p.m., the Board of Executives for Long-Term Services and Support (BELTSS) website, indicated LALD-D held a current assisted living director license. The BELTSS website did not indicate LALD-D was listed as the Director of Record for the licensee.	0 110		

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0 110	Continued From page 2 On March 16, 2022, at approximately 11:00 a.m., O-C acknowledged LALD-D was not listed as the Director of Record for licensee. O-C stated they were not aware of the requirement for the Director of Record. The licensee's undated 4.01 Assisted Living Director policy failed to identify LALD would be listed as the Director of Record for the licensee. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a).	0 430		

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0 430	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) to one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 admitted on May 1, 2020. R1's record lacked documentation R1 received licensee's UDALSA. On March 16, 2022, at approximately 11:00 a.m., owner (O)-C acknowledged no documentation of receipt of licensee's UDALSA would be included in R1's record. O-C stated the licensee had not provided the UDALSA to any resident. The licensee did not provide a policy realted to the UDALSA. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall:	0 450		

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0 450	Continued From page 4 (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the current assisted living bill of rights (BOR) to one of one resident (R1) with record reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1 admitted on May 1, 2020. R1's Home Care Bill of Rights dated April 30, 2020, indicated R1 received the home care BOR, not the current assisted living BOR. On March 16, 2022, at approximately 11:00 a.m., owner (O)-C acknowledged the BOR provided	0 450		

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0 450	Continued From page 5 and documented as received in R1's record was not the current assisted living BOR. O-C indicated the licensee had provided the home care BOR, not the assisted living BOR to all residents. O-C stated the licensee would need to provide and document receipt of current assisted living BOR to all residents. The licensee did not provide a policy related to the assisted living BOR. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450		
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached	0 470		

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0 470	Continued From page 6 building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the staffing plan was posted as required, potentially affecting all the licensee's current residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On March 15, 2022, at approximately 10:00 a.m., the surveyor did not observe a posted staff schedule during a tour of the facility. The licensee lacked a posted daily staffing schedule after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location. On March 16, 2022, at approximately 11:00 a.m., owner (O)-C acknowledged the licensee was not aware a staffing schedule had to be posted for residents, staff, and visitors to be able to access in common area.	0 470		

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0 470	Continued From page 7 The licensee's undated 4.06 Staffing & Scheduling policy indicated the schedule would be posted as required. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 480		

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0 480	Continued From page 8 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated March 15, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	0 680		

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0 680	Continued From page 9 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to impact all residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 15, 2022, at approximately 10:00 a.m. during a tour of the facility, the surveyor did not observe any signage or information regarding the licensee's emergency disaster or preparedness plan posted in a prominent location. On March 15, 2022, at approximately 10:00 a.m., the surveyor requested the licensee's emergency disaster or preparedness plan. Owner (O)-C stated a disaster or emergency preparedness plan for the licensee had not been created. O-C stated since one had not been created, it would not be posted anywhere in the facility. The licensee's undated 9.01 Emergency	0 680		

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0 680	Continued From page 10 Preparedness Plan - Appendix Z Compliance policy indicated the licensee would create and post an emergency preparedness plan with all required content related to Appendix Z. No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780		

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0 780	Continued From page 11 by: Based on observation and interview, the licensee failed to provide the required smoke alarms inside resident bedrooms #1, #2, #3, and #5, and failed to provide properly maintained the smoke smoke alarms outside in the vicinity hallway of the upper level and basement resident room #4. In addition, the licensee failed to provide interconnection of smoke alarms as required by Minnesota Statutes, 144G.45, Subd. 2. This has the potential to directly affect resident(s), staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 15, 2022, between 1:30 p.m. and 2:30 p.m., survey staff toured the home with the owner (O)-C. MISSING SMOKE ALARMS -At approximately 1:35 p.m., staff toured the upper level of the home and observed there were no smoke alarms inside of bedrooms #1, #2, and #3. -At approximately 2:00 p.m., staff toured the basement of the home and observed there was no smoke alarm inside of bedroom #5. MAINTENANCE and INTERCONNECTION of SMOKE ALARMS -At approximately 1:35 p.m., staff toured the upper level of the home and observed the smoke alarm outside of the upper floor bedrooms was	0 780		

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MIDWEST HOMES INC	1628 KELLER DRIVE BURNSVILLE, MN 55306

(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
0 780	Continued From page 12 not secured and loosely hung with exposed wire from the ceiling. When tested by the O-C, it sounded local. Survey staff explained to the O-C that all smoke alarms in the home must sound for notification throughout when one alarm sounds. -At approximately 2:00 p.m., staff toured the basement of the home and observed there the hardwired smoke alarm (with carbon monoxide detection) located outside of bedroom #4 failed to sound. On March 15, 2022, at approximately at 3:00 p.m., during the exit interview, the O-C acknowledged the findings. Survey staff explained that the missing smoke alarms and lack of maintenance of smoke alarms prevent the early notification of fire for the residents which can delay the response time of the evacuation of the entire home. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 15, 2022, from 1:30 p.m. and 2:30 p.m., survey staff toured the home with the owner (O)-C. During the tour, survey staff observed portable fire extinguishers located on the main floor and basement had a tag indicating the last service date of August 2015, and both lacked required monthly visual inspections. Staff explained to the O-C that all portable fire extinguishers must be serviced on an annual basis by a trained person/vendor to perform the required annual service and each extinguisher must be inspected on a monthly basis by an assigned staff at the home. On March 15, 2022, at approximately at 3:00 p.m., during the exit interview, the O-C acknowledged the findings.	0 790		

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0 790	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). On March 15, 2022, between the hours of 1:30 p.m. and 2:30 p.m., survey staff toured the home with the owner(O)-C.	0 800		

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0 800	Continued From page 15 FRONT ENTRY DOOR At approximately 1:35 p.m., survey staff opened the front entrance door but had difficulty opening the door with turning the doorknob. The O-C explained that the doorknob can only be turned to the right only to exit. At approximately 1:50 p.m., survey staff also observed the food service surveyor had similar challenges leaving the home with turning the doorknob to exit at the front door while the O-C attempted to assist. Survey staff explained that the hardware for the front door must be easily opened and functioned in a manner that does not require special knowledge for safe egress. BASEMENT The carbon monoxide detector in the hallway failed to sound when tested. The O-C verified this finding as she stated that it was just this carbon monoxide detector. Staff also asked the O-C about a solid cover over possibly a hardwired carbon monoxide detector or smoke alarm in the furnace room and be maintained it for safety if so. The O-C stated that it was that way since she bought the home. BEDROOM #5 On March 15, 2022, at approximately 2:15 p.m., survey staff entered bedroom #5 in the basement level and noticed there was no visible daylight and asked the O-C if there was a window for the bedroom. The O-C asked her employee about the window and the employee reached and removed a suitcase that completely covered the window and prevent daylight in the room. Thereafter, survey staff measured the windowsill height in bedroom #5 at 70 inches above the finished floor level. As survey staff proceeded to measure the window opening dimensions but was not successful due to the height of the windowsill.	0 800		

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0 800	Continued From page 16 The O-C asked her employee to assist with the measurements. The employee got on the nightstand in the room and placed the tape measure while survey staff took the dimensions of the window openings at 31 inches wide by 20.5 inches height. Survey staff explained to the O-C that the windowsill height for bedroom #5 was measured at 70 inches exceeding the state standard for maximum escape windowsill height allowed of 48 inches for safe egress for existing windows. Survey staff also added that the windowsill height of 70 inches poses a hazard to the resident during a fire or emergency for safe evacuation. Furthermore, the window opening area for this bedroom (# 5) also was calculated at 635 square inches (4.4 square feet) which did not meet the state standard minimum area of at least 648 square inches (4.5 square feet) required for existing egress window openings for bedrooms in assisted living facilities. AIR RETURN GRILLES The air return grilles in the bedrooms were dirty and heavily layered with dust. On March 15, 2022, at about 2:15 p.m. and again at 3:00 p.m. during the exit interview, the O-C acknowledged the findings and stated she will seek out a contractor immediately to correct the window in bedroom #5. Survey staff explained and emphasized to the O-C that she will need to obtain required permit and inspection for the new window dimensions for compliance with current code. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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0 810	Continued From page 17	0 810		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on document review and interview, the	0 810		

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0 810	Continued From page 18 licensee failed to provide the required content of documentation on the fire safety and evacuation plan, required training documentation for employees and residents on the fire safety and evacuation plan, and required documentation of fire and evacuation drills performed by employees. This has the potential to directly affect the safety of visitors, staff, and all residents receiving assisted living care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 15, 2022, from approximately 2:30 p.m to 3:00 p.m., survey staff reviewed the facility's fire safety and evacuation plan documentation, training policies and procedures, and related records. The document review indicated the following: FIRE SAFETY AND EVACUATION PLAN: - Plan documentation lacked specific fire protection procedures necessary for addressing all residents including any unique resident-specific situations during an evacuation. Unique situations during an evacuation may be residents who have mobility limitations, cognitive impairment, or needing assistance during an evacuation and must be addressed in the fire safety and evacuation plan documentation. - Plan documentation lacked documentation of	0 810		

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0 810	Continued From page 19 fire protection procedures for residents. -Plan documentation lacked a building evacuation floor plan to show the location and number of resident sleeping rooms. TRAINING -The licensee failed to meet the minimum frequency of employee training on the fire safety and evacuation plan. The minimum required employee training is upon hire and at least twice a year, thereafter, rather than annually as documented in their policy. -The licensee failed to provide documentation to show training of residents that can self-assist in their evacuation on the proper actions to be taken in the event of a fire including movement, evacuation, or relocation. FIRE AND EVACUATION DRILLS The licensee failed to document the correct minimum number of drills performed by employees twice per year per shift, with at least one evacuation drill every other month. The policy indicated on the scheduled calendar for drills was for January-April-July-October. Record review indicated drills performed and recorded were on April 28, 2021, January 10, 2021, November 3, 2020, and April 27, 2020. On March 15, 2022, at approximately 3:00 p.m., the owner(O)-C acknowledged the above findings at the exit interview. Survey staff advised the O-C that a smoking policy be established and adopted for the safety of all residents inside and outside of the home since staff observed residents smoking in front of the home. No other information was provided. TIME PERIOD FOR CORRECTION: Fourteen	0 810		

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0 810	Continued From page 20 (14) days	0 810		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living	0 950		

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0 950	Continued From page 21 contract included the designation of representatives statutory language for one of one resident (R1) with record reviewed. 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: R1 admitted on May 1, 2020. R1's Housing with Services Contract & Lease Agreement dated November 8, 2021, lacked the verbatim "right to designate a representative for certain purposes" notice required at the time of execution of the contract. On March 16, 2022, at approximately 11:00 a.m., owner (O)-C acknowledged the required verbatim notice was not included in the residents' records. O-C stated the residents are able to designate a representative but the required verbatim notice was not provided to the residents. The licensee lacked a policy related to the content of an assisted living contract which would indicate the verbatim notice would be provided to each resident at the time of contract execution. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		

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0 970	Continued From page 22	0 970		
0 970 SS=F	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 admitted on May 1, 2020. R1's Housing with Services Contract & Lease Agreement dated November 8, 2021, indicated the licensee is not liable for residents' injury, death, or property damage.	0 970		

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0 970	Continued From page 23 On March 16, 2022, at approximately 11:00 a.m., owner (O)-C acknowledged the resident contract contained a liability waiver. O-C stated the contract was drafted as a rental lease and routinely contains liability waivers, but licensee was not aware the contract could not contain such language for assisted living contracts. The licensee lacked a policy related to the content of an assisted living contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and	01440		

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01440	Continued From page 24 thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure supervision was completed within 30 calendar days of beginning to provide delegated tasks for one of one unlicensed personnel (ULP)-B with training record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 16, 2022, at approximately 8:00 a.m., ULP-B provided the delegated task of blood glucose check to R1. ULP-B was hired on August 1, 2021. ULP-B's 2.01 Competencies Tracking Form dated August 18, 2021, indicated ULP-B had completed competency training for blood glucose testing but lacked the signature of the registered nurse who provided the training and competency verification. ULP-B's Comprehensive Home Care RN Competency Training form dated August 19, 2021, indicated ULP-B had completed a training for blood glucose testing but lacked the signature	01440		

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01440	Continued From page 25 of the registered nurse who provided the training and competency verification. On March 16, 2022, at approximately 11:00 a.m., owner (O)-C acknowledged ULP-B's record lacked documentation of supervision for a delegated task within 30 days. O-C stated that the RN does check in with ULPs to ensure delegated tasks are performed correctly, but no documentation of the supervision and checks would be in any ULPs' records. The licensee's undated 6.17 Supervision of Staff - Delegated Services policy indicated RN supervision would be completed within 30 calendar days from the day the task was first delegated and would be documented in the employee's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting	01470		

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01470	Continued From page 26 Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	01470		

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	35647	A. BUILDING: _____ B. WING _____	03/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01470	Continued From page 27 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services for one of two employees (registered nurse (RN)-A) with training records reviewed. 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: RN-A was hired May 1, 2018, under the comprehensive license and began providing assisted living services August 1, 2021. RN-A's My Transcript indicated the last training RN-A completed was October 20, 2020. On March 16, 2022, at approximately 11:00 a.m., owner (O)-C stated RN-A's My Transcript was a complete record of the training RN-A had completed for licensee. O-C acknowledged RN-A's training lacked training or orientation to assisted living statutes, assisted living bill of rights, and licensee's new assisted living policies and procedures.	01470		

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01470	Continued From page 28 The licensee's undated 5.06 Annual Required Staff Training policy indicated all employees would have all required orientation and training for assisted living licensure and documented in the employee record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01620 SS=F	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 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.	01620		

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01620	Continued From page 29 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive nursing assessment to include all areas identified on the uniform assessment tool for one of one resident (R1) with record reviewed. 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: R1 admitted to the licensee on May 1, 2020. R1's diagnoses included schizoaffective disorder, diabetes mellitus, congestive heart failure, and moderate intellectual disability. R1's record include two Nurse Reassessment Visits dated February 2, 2022, and December 4, 2021, which were a one-page document and lacked a comprehensive assessment to include all areas on the uniform assessment tool. The document failed to assess resident's personal lifestyle preferences, activities of daily living, physical health status, skin conditions, list of treatments, nursing needs, risk factors, decision making authority, and need for follow up referrals. On March 16, 2022, at approximately 11:00 a.m., owner (O)-C indicated the Nurse Reassessment Visit document was used as the licensee's nursing assessment for all residents. O-C	01620		

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01620	Continued From page 30 indicated the licensee was not aware of the uniform assessment tool. Once directed to review the uniform assessment tool, O-C acknowledged the licensee's assessment lacked multiple areas required to be assessed by the RN. The licensee's undated 6.03 Uniform Assessment Tool policy identified all required areas on the uniform assessment tool to be completed with each nursing assessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an opened insulin pen was dated either when the insulin was opened or would expire for one of one resident (R1) with record reviewed. 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	01890		

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01890	Continued From page 31 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 March 16, 2022, at approximately 8:00 a.m., unlicensed personnel (ULP)-B assisted R1 to administer their own insulin order after ULP-B verified the dose. R1's insulin pen lacked documentation of an opened by or discard by date on the insulin pen. ULP-B stated they were trained by the registered nurse (RN) on how to administer R1's insulin and an open by date should have been included on the insulin pen on the date the pen was first used. R1 admitted on May 1, 2020, with diagnoses of diabetes mellitus, schizoaffective disorder, congestive heart failure, and hypertension (high blood pressure). R1's Medication Administration record dated March 2022 read, Lantus Solostar Pen U-100 Insulin 100 unit/ml (3ml) subcutaneous. Inject 18 Units subcutaneous every morning. On March 16, 2022, at approximately 11:00 a.m., owner (O)-C acknowledged R1's insulin pen lacked an opened on date. O-C stated all insulin pens should have an opened on date placed by the employee who first uses the pen. O-C stated each employee is trained by the RN and has been instructed to place the opened on date on the pen. The licensee lacked a policy for placing an opened by date on insulin pens.	01890		

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01890	Continued From page 32 No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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 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.	01940		

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01940	Continued From page 33 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual treatment management record to include all required content was developed for one of one resident (R1) who received a treatment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 16, 2022, at approximately 8:00 a.m., unlicensed personnel (ULP)-B assisted R1 to obtained blood sugar level (blood glucose or level of glucose in a person's blood) and administer insulin order after ULP-B verified the blood sugar level and dose of insulin. R1 self-obtained blood sugar appropriately and was able to verbalize skill steps to ULP-B during the process. R1 admitted on May 1, 2020, with diagnoses of diabetes mellitus, schizoaffective disorder, congestive heart failure, and hypertension (high blood pressure). R1's Service Plan-IAPP dated May 1, 2021, lacked identification of blood sugar treatment service to be provided by licensee. R1's Treatment Plan dated May 1, 2021, lacked identification of blood sugar treatment, and all required components of a treatment management	01940		

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01940	Continued From page 34 record for blood sugar. R1's Client Profile with print date of March 15, 2022, at 12:45 p.m., indicated blood sugar to be checked four times per day. R1's Medical Charting Detailed Report for Blood Sugar dated March 9, 2022, through March 16, 2022, indicated R1's blood sugar was obtained four times per day and recorded by the ULP who observed R1 complete the blood sugar check. On March 16, 2022, at approximately 11:00 a.m., owner (O)-C acknowledged R1's blood sugar treatment management record was not created. Although R1's order did indicate a range when to contact a nurse, the treatment management record did not indicate where the information would be located, and licensee failed to indicate treatment services are provided on R1's service plan. The licensee's undated 7.05 Treatment & Therapy Management Plan policy indicated the required contents of a treatment management record and would be included on the resident's service plan. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio	03090		

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03090	Continued From page 35 devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at the main entry way of the licensee's facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 15, 2022, at approximately 10:00 a.m., during the tour of the facility, the surveyor observed cameras throughout the facility, but no electronic monitoring notice posted in the licensee's facility with the statutory required language. On March 16, 2022, at approximately 11:00 a.m., owner (O)-C acknowledged the licensee failed to post the required electronic monitoring notice. O-C indicated electronic monitoring occurs within the licensee's facility, but the licensee failed to	03090		

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03090	Continued From page 36 post the required notice at the main entrance. The licensee's undated 2.15 Electronic Monitoring policy indicated the licensee would post the electronic monitoring notice to include the required language at entrances accessible to visitors. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Type: Full
Date: *03/15/22*
Time: 13:40:24
Report: 8075221060

Food and Beverage Establishment Inspection Report

Location:
Midwest Homes Inc
1628 Keller Drive
Burnsville, MN55306
Dakota County, 19

Establishment Info:
ID #: 0038177
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6128651874
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

Dishes are currently not being sanitized. Dish machine reportedly has a mechanical and/or plumbing problem. Repair, then ensure (using thermolabels left onsite) that dish machine reaches the 160 degrees utensil surface temperature.

Comply By: 03/31/22

2-100 Supervision

2-102.12AMN

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

No state certified food protection manager.

Comply By: 09/15/22

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: fridge - deli meat
Violation Issued: No

Type: Full
Date: *03/15/22*
Time: 13:40:24
Report: 8075221060
Midwest Homes Inc

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: fridge - stirfry
Violation Issued: No

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

Note: Facility prepares time/temperature control for safety food for same day service. In accordance with MN Rules, part 4626.0506, subpart G, facility is exempt from the equipment requirements of MN Rules, part 4626.0506, subpart A.

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 8075221060 of 03/15/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____
Regina Stepney
Director of Operations

Signed: Erin Tibbetts
Erin Tibbetts
Public Health Sanitarian
Metro District Office
651-201-3987
erin.tibbetts@state.mn.us