Electronically Delivered

April 17, 2026

Licensee
BRIGHTVIEW A.L INC
1012 28th Street West
Minneapolis, MN 55408

RE: Project Number(s) SL41604015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on March 16, 2026, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the

correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's residents/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.

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	41604	A. BUILDING: _____ B. WING _____	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	1012 28TH ST W MINNEAPOLIS, MN 55408

(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: SL41604015-0 On March 9, 2026, through March 16, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents residing in the facility, all three were receiving services under the Provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 1 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include TB screening that included a two-step tuberculin skin test (TST) or single TB blood test, and a history and symptom screening completed upon hire for two of two employees (clinical nurse supervisor (CNS)-B and 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 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).	0 660		

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0 660	Continued From page 2 The findings include: The Facility TB Risk Assessment dated January 2, 2026, indicated the facility had a low risk for TB transmission. CNS-B CNS-B was hired January 1, 2026 , to oversee and manage the daily clinical operations of the licensee, staff supervision and provide direct care and services to residents. On March 10, 2026, between 8:30 a.m., and 2:30 p.m., the surveyor observed CNS-B providing supervision to the licensee's staff and clinical services to residents in the facility. CNS-B's record included TB blood test results, with negative results dated July 18, 2025, greater than 90 days (126 days) prior to hire. CNS-B's record lacked a baseline TB screening test completed upon hire or within 90 days prior to hire, and lacked documentation of history and symptom screening completed upon hire. ULP-D ULP-D was hired September 6, 2025, to provide direct care for residents. On March 10, 2026, between 8:30 a.m., and 11:30 a.m., the surveyor observed ULP-D assist R1 with medication administration, meal preparation and reminders for activities of daily living and safety. ULP-D's record included documentation of a TST administered December 16, 2025, and read as negative December 18, 2025. ULP-D's record lacked TB screening completed upon hire, prior	0 660		

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0 660	Continued From page 3 to working with residents. The record lacked documentation of a second-step TST and further lacked documentation of history and symptom screening completed upon hire. On March 12, 2026, at 3:45 p.m., licensed assisted living director (LALD)-A stated the licensee thought they were following the Minnesota statute related to TB but now realized the licensee needed to research and correct the inconsistencies. House manager (HM)-C added the licensee now understood the TST required two injections and two readings. HM-B stated the licensee would uniformly use a blood test for all future employees. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines indicated, 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. In addition, "An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the healthcare worker (HCW) starts working with patients." The MDH Assisted Living Resources and Frequently Asked Questions website updated December 13, 2024, included under Tuberculosis Screening, "Each facility must establish and	0 660		

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0 660	Continued From page 4 maintain a comprehensive TB infection control program according to the most current tuberculosis infection control guidelines issued by the United States 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 licensee's Infection Control policy, effective date September 1, 2025, indicated, "All staff whose essential job functions require work within the same air space of assisted living residents shall be screened and tested for tuberculosis. The facility shall have an ongoing program for screening and educating staff on tuberculosis and have an infection control plan for handling persons with active tuberculosis. All staff whose essential job functions require work within the same air space of assisted living residents shall be screened and tested for tuberculosis prior to the staff being exposed to residents." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680		

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0 680	Continued From page 5 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 residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content. In addition, the licensee failed to ensure the missing resident policy was reviewed quarterly as required under section 4659.0110. This had the potential to affect all current 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, 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).	0 680		

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0 680	Continued From page 6 The findings include: The licensee's emergency preparedness plan (EPP), last reviewed December 1, 2025, lacked customization to the facility and lacked an emergency program that described the facility's approach to meeting health/safety/security needs of staff/residents and how facility would coordinate with other health care facilities, as well as community on a whole during emergency or disaster, including the following: - arrangements/contracts to re-establish utility services. - strategies for addressing facility and community-based risks including staffing surges/shortages, and back-up plans. - process for cooperation and collaboration with local, tribal, regional, State and Federal emergency program. - policies and procedures based on the EP, risk assessment, and communication plan to address the following: - food, water, medical supplies, and pharmaceutical supplies whether evacuated or sheltered in place for staff and residents. - alternate sources of energy to maintain temperatures, safe/sanitary storage, emergency lighting, and sewage and waste disposal. - system to track the location of on-duty staff and sheltered residents. - safe evacuation from the facility, including consideration of care/treatment needs of evacuees, staff responsibilities, transportation, identification of evacuation locations, primary/alternate communication means with external sources of assistance. -system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records.	0 680		

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0 680	Continued From page 7 -use of volunteers, including the process/role for integration. -development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents. communication plan that included: -all the following names/contact information for staff, entities providing services under agreement, residents physicians, other facilities, and volunteers -information for Federal, State, tribal, regional, and local EP staff, state licensing, and certification agency. -primary and alternate means of communication with facility staff and Federal, State, regional and local emergency management agencies. -method to share information and medical documentation, release of information as permitted under 45 CFR 164.510(b)(1)(ii). -means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction. -method for sharing information about EP with residents and their families/representatives. On March 12, 2026, at 3:45 p.m.., licensed assisted living director (LALD)-A stated the licensee needed to develop a comprehensive program for emergencies to ensure resident and staff safety. LALD-A explained the licensee purchased the program from an agency and assumed it was complete and accurate. LALD-A stated the licensee would make corrections and review on a regular basis. The Licensee's Emergency Preparedness Plan policy, dated June 2, 2025, indicated the licensee: "will have an identified plan in place to assure the safety and well-being of residents and staff during	0 680		

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0 680	Continued From page 8 periods of an emergency or disaster that disrupts services. The plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents. Brightview AL will implement the Emergency Management program as soon as the agency becomes aware of the existence of an emergency." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 950 SS=C	144G.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	0 950		

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0 950	Continued From page 9 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 resident was given the opportunity to identify a designated representative in writing in the contract assisted living contract, or to document if the resident declined to designate a representative, for one of one resident (R1). 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: R1 was admitted to the facility on September 3, 2025, and had diagnoses including diabetes mellitus type two, fracture of lower right leg, age-related debility and frailty, chronic obstructive pulmonary disease. R1's Assisted Living Contract signed September 26, 2025, included the required verbatim notice for designation of representatives in writing, but lacked identification of a designated	0 950		

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0 950	Continued From page 10 representative or a box initialed if the resident declined to identify a designated representative. On March 12, 2026, at 3:45 p.m., licensed assisted living director (LALD)-A stated they were not aware of the need to provide a specific area to decline for residents to decline a designated representative in the contract. LALD-A stated the licensee would correct current resident contracts and ensure all new residents had an area to decline a representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
0 970 SS=C	144G.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 for one of one resident (R1). This practice resulted in a level one violation (a violation that will cause only minimal impact on	0 970		

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0 970	Continued From page 11 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: R1 was admitted to the facility on September 3, 2025, and had diagnoses including diabetes mellitus type two, fracture of lower right leg, age-related debilty and frailty, and chronic obstructive pulmonary disease. R1's Assisted Living Contract signed September 26, 2025, included the following language indicating waivers of liability: Miscellaneous Provisions and Responsibilities "The resident is responsible to protect their own interests outside what is covered in this Agreement. The resident acknowledges that [licensee] is not an insurer of the resident's person or property. The resident agrees that resident shall be responsible for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] Assisted Living or its employees or agents." On March 12, 2026, at 3:45 p.m., house manager (HM)-C stated they were not aware the waiver was in resident contracts. HM-B explained the licensee bought the contract from a health care agency and assumed the contracts were compliant to the statutes. HM-B stated the licensee would make all needed corrections for	0 970		

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0 970	Continued From page 12 current and future residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency	01460		

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BRIGHTVIEW AL INC	1012 28TH ST W MINNEAPOLIS, MN 55408

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01460	Continued From page 13 procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. 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 (clinical nurse supervisor (CNS)-B). 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: CNS-B was hired January 1, 2026, to oversee and manage the daily clinical operations of the facility, staff supervision and provide direct care and services to residents residing in the facility. On March 10, 2026, between 8:30 a.m., and 2:30 p.m., the surveyor observed CNS-B providing guidance to the licensee's staff and clinical services to residents in the facility. CNS-B's employee record lacked documentation of orientation to assisted living regulations as follows:	01460		

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01460	Continued From page 14 -overview of assisted living statutes and chapter 144G; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling emergencies and using emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -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 -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On March 12, 2026, at 3:45 p.m., during the exit conference, licensed assisted living director (LALD)-A stated the licensee expected all orientation to be completed prior to that employee working directly with residents. CNS-B stated they were unaware of the orientation but already started completing it and would incorporate this	01460		

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01460	Continued From page 15 into the plan of correction. The licensee's Staff Orientation and Education policy dated, June 2, 2025, indicated, "No one may provide direct care to residents on behalf of [licensee] before successfully completing the organization ' s orientation program." The policy further indicated, "[Licensee] will maintain proof of orientation in the personnel files." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing assisted living services were oriented specifically to each individual resident and the services to be provided to each resident for two of two employees (clinical nurse supervisor (CNS)-B and 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 is issued at a widespread scope (when problems	01480		

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01480	Continued From page 16 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: CNS-B CNS-B was hired January 1, 2026, to oversee and manage the daily clinical operations of the facility, staff supervision and provide direct care and services to residents residing in the facility. On March 10, 2026, between 8:30 a.m., and 2:30 p.m., the surveyor observed CNS-B providing guidance to the licensee's staff and clinical services to residents in the facility. CNS-B's employee record lacked documentation CNS-B was oriented specifically to each individual resident and the services to be provided. ULP-D ULP-D was hired September 6, 2025, to provide direct care for residents. On March 10, 2026, between 8:30 a.m., and 11:30 a.m., the surveyor observed ULP-D assist R1 with medication administration, meal preparation and reminders for activities of daily living and safety. ULP-D's employee record lacked documentation ULP-D was oriented specifically to each individual resident and the services to be provided. On March 12, 2026, at 3:45 p.m., licensed assisted living director (LALD)-A stated although verbal orientation of residents was provided, the licensee did not document the process. LALD-A	01480		

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01480	Continued From page 17 explained the licensee would develop a plan to ensure all staff were oriented to each resident and their needs before the employees work with the residents. The licensee's Staff Orientation and Education policy dated, June 2, 2025, indicated, "Following general orientation, employees providing direct care receive specific orientation to each individual resident and the services to be provided. Staff providing assisted living will also be oriented to the individual resident's services. This orientation may be provided in person, in writing or electronically." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01480		
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least	01530		

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01530	Continued From page 18 eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received at least eight hours of initial training on dementia topics, and the required 2 hours of initial training on mental illness and de-escalation topics within 120 hours of start date for one of two employees (clinical nurse supervisor (CNS)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01530		

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01530	Continued From page 19 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: CNS-B was hired January 1, 2026, to oversee and manage the daily clinical operations of the facility, staff supervision and provide direct care and services to residents residing in the facility. On March 10, 2026, between 8:30 a.m., and 2:30 p.m., the surveyor observed CNS-B providing guidance to the licensee's staff and clinical services to residents in the facility. CNS-B's employee record lacked documentation she completed the required eight hours of dementia care training and the required 2 hours of initial training on mental illness and de-escalation topics within 120 hours of the start date for supervisors of direct-care staff. On March 12, 2026, at 3:45 p.m., CNS- B stated they had not completed the required mental illness training, or eight hours of dementia training. House manager (HM)-C stated the licensee was aware of the required dementia and mental illness and de-escalation training. HM-C explained the licensee would ensure all staff completed the required training. The licensee's Staff Orientation and Education policy, dated June 2, 2025, indicated all direct care staff and supervisors providing direct services must receive training on dementia and mental illness with de-escalation. No further information was provided.	01530		

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01530	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (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	01730		

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01730	Continued From page 21 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 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 an individualized medication management plan with the required content for one of one resident (R1). 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: During the entrance conference on March 9, 2026, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents residing in the facility. R1 had diagnoses including diabetes mellitus type two, fracture of lower right leg, age-related debility and frailty, chronic obstructive pulmonary disease.	01730		

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01730	Continued From page 22 R1's service plan dated September 4, 2025, indicated R1 received services including assistance with medication management. On March 10, 2026, at approximately 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-D assisting R1 with medication administration, which included the following eye medications: -ketorolac tromethamine 0.4%, (indication of cataract surgery) one drop to right eye, -moxifloxacin 0.5 %, (indication of cataract surgery) one drop to right eye, and -prednisolone acetate 1.0%, (indication of cataract surgery), one drop to right eye. After administering the first eye medication (ketorolac), ULP-D waited 35 seconds, then administered the second eye medication (moxifloxacin). After waiting 42 seconds, ULP-D administered the third eye medication (prednisolone acetate). ULP-D failed to wait five minutes between eye medications, as is standard practice, and recommended by the manufacturer. Further, ULP-D failed to apply pressure to the nasolacrimal duct (a duct running from the eye to the nose) when administering moxifloxacin, as recommended. ULP-D then assisted R1 with blood glucose monitoring and insulin administration. After obtaining the blood glucose reading, ULP-D informed R1 the blood glucose level was 107. R1 stated, "I will take 12 units [of insulin]." -When asked by the surveyor, ULP-D stated they did not know what the blood glucose reading meant, when they should call the nurse or how much insulin to administer. ULP-D explained "This was what I was told to do." ULP-D further stated they were not instructed to wait any amount of time between eye drops and those	01730		

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01730	Continued From page 23 instructions were not documented on the electronic medication administration record. R1's medication management plan, dated September 4, 2025, indicated R1 required assistance with medication administration including insulin injections, eye drop application and oral medications, however, the plan lacked: - documentation of specific resident instructions relating to medication administration, and - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. On March 10, 2026, at 9:10 a.m., CNS-B stated she had been recently hired, and explained she was not familiar with all the assisted living statutes because she had not previously worked in this environment. On March 12, 2026, at 3:45 p.m., CNS-B stated this was ultimately her responsibility to ensure effective administration of medications. The licensee's Service Plan for Medication Management policy dated June 2, 2025, indicated: -registered nurse was responsible for preparing and documenting the medication management plan -medication management plan would be kept current and updated with any changes, and -any resident-specific requirements related to documenting medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that prior to delegating the task of medication administration, the registered nurse had instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures, specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and communicated with the unlicensed personnel about the individual needs of the resident for one of one resident (R1). 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	01750		

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01750	Continued From page 25 portion or all of the residents). The findings include: R1 had diagnoses including diabetes mellitus type two, fracture of lower right leg, age-related debilty and frailty, chronic obstructive pulmonary disease. R1's service plan dated September 4, 2025, indicated R1 received services including assistance with medication management. R1's medication assessment, dated September 4, 2025, indicated, "The most accurate list of all medications the client is taking has been reviewed by a nurse including the name of the medication, the dose, the frequency and route of medication." The assessment further indicated R1 was unable to correctly state what medications were to be taken, what each medication was for, or the proper dosage of medications. R1's most recent nursing assessment, completed by clinical nurse supervisor (CNS)-B on February 4, 2026, indicated R1 needed help with medication administration, and self-administration of medications was not appropriate. INSULIN On March 10, 2026, at 8:33 a.m., the surveyor observed unlicensed personnel (ULP)-D assist R1 with blood glucose monitoring and insulin administration. After obtaining the blood glucose reading, ULP-D informed R1 the blood glucose level was 107. R1 stated, "I will take 12 units [of insulin]." When asked, ULP-D stated they did not know what the blood glucose reading meant or how much insulin to administer. ULP-D explained	01750		

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01750	Continued From page 26 "This was what I was told to do." -R1 stated he decided how much insulin to take depending on the amount of food he planned to consume. R1 stated, "I have been doing this since 2009. I count the [carbohydrates] mentally in my head." R1's medication profile order sheet, dated August 10, 2025, indicated Humolog Kwikpen, 10-15 units three times each day for Diabetes type 2. The order lacked a specified dosage or sliding scale for the amount of insulin to be given correlated to the blood glucose level. EYE MEDICATIONS On March 10, 2026, at 8:33 a.m., the surveyor observed ULP-D assisting R1 with medication administration including the following eye drops: -ketorolac tromethamine (for cataract surgery) 0.4%, one drop to right eye, -moxifloxacin (for cataract surgery) 0.5 %, one drop to right eye, and -prednisone acetate (for cataract surgery) 1.0%, one drop to right eye. After administering the first eye medication (ketorolac), ULP-D waited 35 seconds, then administered the second eye medication (moxifloxacin). After waiting 42 seconds, ULP-D administered the third eye medication (prednisolone acetate. ULP-D failed to wait five minutes between eye medications, as was standard practice, and recommended by the manufacturer. Further, ULP-D failed to apply pressure to the nasolacrimal duct (a duct running from the eye to the nose) when administering moxifloxacin, as recommended. When asked, ULP-D stated they were not instructed to wait any amount of time between eye drops and instructions were not documented	01750		

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	41604	A. BUILDING: _____ B. WING _____	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTVIEW AL INC	1012 28TH ST W MINNEAPOLIS, MN 55408

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01750	Continued From page 27 on the electronic medication administration record. ULP-D stated, "This is what I was told to do." Manufacturer directions for administration of moxifloxacin eye drops, dated September 24, 2021, indicated, "...the nasolacrimal ducts should be held closed for 2 to 3 minutes with the fingers after administering the drops." The directions further indicated, "If more than one topical ophthalmic medicinal product is being used, the medicinal products must be administered at least 5 minutes apart." Manufacturer directions for administration of ketorolac eye drops, dated October 2017, indicated, "Patients should be advised that if more than one topical ophthalmic medication is being used, the medicines should be administered at least 5 minutes apart." The American Society of Ophthalmic Registered Nurses guidance, "Instillation of Eye Drops and Ointments" undated, indicated, "If administering more than one medication to the eye, ask patient to close eyes for 30 seconds after each drop. Administer ophthalmic ointment last. Wait 5 minutes between instillation of medications (or per MD order)." On March 10, 2026, at 9:10 a.m., CNS-B stated she had been hired recently, and explained she was not familiar with all the assisted living statutes because she had not previously worked in this environment. On March 12, 2026, at 3:45 p.m., CNS-B stated ULP-D had been trained prior to her employment and she expected ULPs to be adequately trained in all areas of medication administration prior to	01750		

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01750	Continued From page 28 administering medications. -Licensed assisted living director (LALD)-A stated the licensee had been in transition of hiring a new CNS and thought all ULPs had been trained, but may have been overlooked due to some confusion. The licensee's Medication Administration policy dated June 2, 2025, indicated, "The Registered Nurse may delegate medication administration to an unlicensed staff member (home health aide) according to the following protocol. a. All home health aides have passed a competency evaluation with respect to all medication routes to be administered b. The Registered Nurse has prepared written instructions for the home health aide in the proper methods to administer medications with respect to each resident c. The Registered Nurse has communicated with/provided orientation to the home health aide regarding the individual needs of the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01820		

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01820	Continued From page 29 review, the licensee failed to ensure there was a complete prescription as defined in section 151.01 for medications managed by the licensee for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the facility on September 4, 2025, and had diagnoses including diabetes mellitus type two, fracture of lower right leg, age-related debilty and frailty, chronic obstructive pulmonary disease. R1's Service plan dated September 4, 2025, indicated R1 received services including assistance with medication management. R1's medication management plan, dated September 4, 2025, indicated R1 required assistance with medication administration including insulin injections, eye drop application and oral medications. On March 10, 2026, at 8:33 a.m., the surveyor observed unlicensed personnel (ULP)-D assist R1 with blood glucose monitoring and insulin administration. After obtaining the blood glucose reading, ULP-D informed R1 the blood glucose level was 107. R1 stated, "I will take 12 units [of insulin]."	01820		

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01820	Continued From page 30 -When asked by the surveyor, ULP-D stated they did not know what the blood glucose reading meant, when to call the nurse or how much insulin to administer. ULP-D explained "This was what I was told to do." -R1 stated he decided how much insulin to take depending on the amount of food he planned to eat. R1 stated, "I have been doing this since 2009. I count the [carbohydrates] mentally in my head." R1's medication profile order sheet, signed August 10, 2025, indicated Humolog Kwikpen, 10-15 units three times each day for Diabetes type 2. The order lacked a specified dosage or sliding scale for the amount of insulin to be given correlated to the blood glucose level. R1's record lacked evidence clinical nurse supervisor (CNS)-B attempted to contact R1's medical provider to clarify the prescribed insulin dosage. R1's medication assessment, dated September 4, 2025, indicated, "The most accurate list of all medications the client is taking has been reviewed by a nurse including the name of the medication, the dose, the frequency and route of medication." The assessment further indicated R1 was unable to correctly state what medications were to be taken, what each medication was for, or the proper dosage of medications. R1's most recent nursing assessment, completed by CNS-B on February 4, 2026, indicated R1 needed help with medication administration, and self-administration of medications was not appropriate.	01820		

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01820	Continued From page 31 On March 10, 2026, at 9:10 a.m., CNS-B stated since she was recently hired, she assumed the order was correct and R1 was able to decide how much insulin he needed. CNS-B explained she was not familiar with all the assisted living statutes because she had not previously worked in the environment. On March 12, 2026, at 3:45 p.m., licensed assisted living director (LALD)-A stated the incomplete order was overlooked because the previous CNS was responsible for the order. LALD-A stated the licensee would review all past orders to ensure they were complete and correct and monitor staff to ensure accuracy. CNS-B added she now understood the process. The licensee's Prescriber's Orders policy dated, June 2, 2025, indicated the licensee "will provide all medically delegated services under an authorized prescriber's orders when indicated. Medication orders would include the name of the medication, dosage, and direction for use." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=F	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.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 32 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for one of one resident (R1). 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: R1 was admitted to the facility on September 4, 2025, and had diagnoses including diabetes mellitus type two, fracture of lower right leg, age-related debilty and frailty, chronic obstructive pulmonary disease. R1's service plan dated September 4, 2025, indicated R1 received services including assistance with medication management. On March 10, 2026, at 10:20 p.m., the surveyor observed the licensee's medication refrigerator and storage system, and identified medications belonging to R1, including the following: In medication refrigerator: -opened/in-use Lantus Solostar (long-acting insulin) 100 unit/milliliter (u/ml) insulin pen; lacked the date the pen had been opened and would expire, and	01890		

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01890	Continued From page 33 -opened/in-use Humalog Kwik pen (short acting insulin) 100 u/ml insulin pen; lacked the date the pen had been opened and would expire. In storage cabinet: -opened/in-use moxifloxacin hydrochloride 0.5% eye drops; lacked the date the bottle had been opened and would expire. On March 10, 2026, at 10:33 a.m., unlicensed personnel (ULP)-D stated they were not trained to write the date when a medication with a shortened expiration date was opened on the medication label. ULP-D stated they used the expiration date printed on the box or the medication bottle. The manufacturer's guidelines for Lantus Solostar (Sanofi) dated 2022, indicated, "After its first use, don ' t refrigerate the Lantus SoloStar pen. Keep it at room temperature only (below 86°F). After 28 days, throw your opened Lantus pen away even if it still has insulin in it." The manufacturer's guidelines for Humalog Kwikpen (Eli Lily) dated 2023, indicated, "Store the Pen you are currently using at room temperature [up to 86°F (30°C)]. Keep away from heat and light. Throw away the HUMALOG Pen you are using after 28 days, even if it still has insulin left in it." The manufacturer's guidelines for moxifloxacin hydrochloride 0.5% eye drops (Brown & Burk) dated September 24, 2021 indicated, "Discard 4 weeks after first opening". On March 12, 2026, at 3:45 p.m., licensed assisted living director (LALD)-A stated ULPs should be educated on and follow the guidelines of time-sensitive medications once opened.	01890		

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01890	Continued From page 34 Clinical nurse supervisor (CNS)-B stated this was ultimately her responsibility to ensure safe medication storage and effective administration of medications. CNS-B stated they would check the medication storage each week with her medication set-up services at the facility. The licensee's Storage/Control of Medications policy dated June 2, 2025, indicated "When [licensee] is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. The licensed nurse is responsible for dating time-sensitive medications when opened." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Brightview AL inc
1012 28th St W
Mineapolis, MN 55408
Hennepin County
Parcel:

Phone:

License Info

License: HFID 41604

Risk:
License:
Expires on:
CFPM: IBRAHIM DEMMAJ
CFPM #: PENDING; Exp:

Inspection Info

Report Number: F8087261046
Inspection Type: Full - Single
Date: 3/10/2026 Time: 3:00:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF OWNER IBRAHIM DEMMAJ.

THE FOLLOWING OBSERVATIONS WERE MADE:

CEILING: PAINTED, KNOCK-DOWN, APPEARS TO BE DURABLE - NON-COMPLIANT
FLOORS: HARDWOOD - NON-COMPLIANT
COUNTERTOPS: QUARTZ - NON COMPLIANT
CABINETS: WOOD - NON COMPLIANT
REFRIGERATOR/FREEZER: KITCHEN-AID
DISHWASHER: FRIGIDARE
STOVE/RANGE: GE
MICROWAVE: WHIRLPOOL
HAND WASHING SINK: YES - LEFT SIDE OF 2-BIN STAINLESS STEEL KITCHEN SINK

NON COMPLIANT FLOOR, CIELING, AND CABINETS ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION. TEMPERATURE PROBE USED TO ENSURE UTENSIL SURFACE TEMPERATURES REACH 160.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

INSPECTION REPORT EMAILED TO FACILITY AND HRD NURSE SURVEYOR MARY BRUESS.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F8087261046 from 3/10/2026

John Boettcher

IBRAHIM DEMMAJ
OWNER

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Brightview AL inc
Mineapolis
County/Group: Hennepin County

Inspection Info

Report Number: F8087261046
Inspection Type: Full
Date: 3/10/2026
Time: 3:00:00 PM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHEESE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT MELON**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Freezer at 0 Degrees F.
Comment:
Violation Issued?: No