Electronically Delivered

February 10, 2026

Licensee
Restoration Services Of Mn Inc
417 Minnesota Street
Sandstone, MN 55072

RE: Project Number(s) SL32242016

Dear Licensee:

On February 5, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on September 18, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

KKM

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 19, 2025

Licensee
Restoration Services of Minnesota, Inc.
417 Minnesota Street
Sandstone, MN 55072

RE: Project Number(s) SL32242016

Dear Licensee:

On December 11, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on September 18, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 18, 2025 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 18, 2024, found not corrected at the time of the December 11, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0775-Fire Protection And Physical Environment-144g.45 Subd. 2. (a)

The details of the violations noted at the time of this follow-up survey completed on December 11, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

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

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

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

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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

Sincerely,

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32242	A. BUILDING: _____ B. WING _____	R 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTORATION SERVICES OF MN INC	417 MINNESOTA STREET SANDSTONE, MN 55072

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS 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: SL32242016-1 On December 9, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on September 18, 2025. At the time of the survey, there were five residents; five receiving services under the Assisted Living Facility license. As a result of the follow-up survey, the following order was reissued.	{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.	
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services	{0 485}		

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{0 485}	Continued From page 1 (a) All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by:	{0 485}	Not reviewed during this survey.	
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of	{0 660}		

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{0 660}	Continued From page 2 the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}	Not reviewed during this survey.	
{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 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:	{0 680}		

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{0 680}	Continued From page 3	{0 680}	Not reviewed during this survey.	
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to comply with Minnesota Fire Code, Minnesota Rules 7511. This had the potential to directly affect four residents and all 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 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 December 9, 2025, the surveyor emailed the licensee and requested follow-up survey documentation and a plan of correction. On December 9, 2025, the licensee responded by email: -Working with an architect on certified construction documents (anticipate completion of this by end of this week or early next week) - Licensed contractors on standby to complete install once all approvals/permits are in place	{0 775}		

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{0 775}	Continued From page 4 - City of Sandstone building permit in place - Windows purchased and the dimensions provided for each sleeping room - Fire watch records were provided for occupied resident sleeping rooms 1, 2, 3, and 4 - Licensee indicated they had gotten permits from the city of Sandstone and recently found out they needed to complete the plan review process with the Department of Labor and Industry which caused a delay in the completion of the egress window replacement - A plan review application for the egress window replacements was submitted to Minnesota Department of Health Engineering Services on October 22, 2025 Record review of the available documentation indicated the egress windows in occupied resident sleeping rooms 1, 2, 3, and 4, were still not compliant on the day of the follow up. The licensee provided documentation indicating they maintained a continuous fire watch log from the initial issue of the immediate order on September 16, 2025, to the current date of the follow-up survey. Previous survey findings: EGRESS WINDOWS OCCUPIED SLEEPING ROOMS On September 16, 2025, at 11:10 a.m., the surveyor toured the facility with director of maintenance (DM)-D and clinical nurse supervisor (CNS)-B. The egress windows in occupied resident sleeping rooms were opened by DM-D and measured by the surveyor. The egress windows in occupied resident sleeping rooms 1, 2, 3, and 4 did not meet the minimum requirements for safe egress. Egress window measurements:	{0 775}		

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{0 775}	Continued From page 5 Occupied sleeping room 1 - the clear open area of the window measured 17.25 inches width, 43.125 inches height, with a total clear area of 743 square inches. The windowsill height from the floor to the clear opening of the window measured 36 inches. Occupied sleeping room 2 - the clear open area of window 1 measured 18 inches width, 43 inches height, with a total clear area of 774 square inches. The clear open area of the window 2 measured 17.25 inches width, 43.125 inches height, with a total clear area of 743 square inches. The windowsill height from the floor to the clear opening of the window measured 36 inches. Occupied sleeping room 3 - the clear open area of the window measured 16.25 inches width, 31.125 inches height, with a total clear area of 505 square inches. The windowsill height from the floor to the clear opening of the window measured 48 inches. Occupied sleeping room 4 - the clear open area of the window 1 measured 16 inches width, 31.125 inches height, with a total clear area of 498 square inches. The clear open area of the window 2 measured 17.5 inches width, 31.125 inches height, with a total clear area of 544 square inches. The windowsill height from the floor to the clear opening of the window measured 48 inches. During the facility tour interview, DM-D and CNS-B verified the egress window measurements. CNS-B stated the licensee was already aware the egress windows were too small and employees had been completing safety checks and fire watches. Record review indicated employees were conducting fire watches at a frequency of every 15 minutes or every 30 minutes.	{0 775}		

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{0 775}	Continued From page 6 One window in each resident sleeping room must meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet). The windowsill height from the floor to the clear opening must be no more than 48 inches. Escape windowsills with clear openings up to 52 inches off the floor may meet the height requirement for existing buildings by securing a step, platform, or bed directly under the window.	{0 775}		
{0 780} SS=E	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;	{0 780}		

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{0 780}	Continued From page 7 This MN Requirement is not met as evidenced by:	{0 780}	Not reviewed during this survey.	
{0 810} SS=E	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) staff 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) Staff 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 staff twice per year per shift with at least one evacuation drill	{0 810}		

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{0 810}	Continued From page 8 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:	{0 810}	Not reviewed during this survey.	
{01290} SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	{01290}	Not reviewed during this survey.	

Electronically Delivered

October 15, 2025

Licensee
Restoration Services of MN Inc
417 Minnesota Street
Sandstone, MN 55072

RE: Project Number(s) SL32242016

Dear Licensee:

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

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

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

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

The correction order documentation should include the following:

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

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

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

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,

Jessie Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL32242016-0 On September 15, 2025, through September 18, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were five residents; five receiving services under the Assisted Living Facility license. An immediate correction order was identified on September 16, 2025, issued for SL32242016-0, tag identification 0775, issued at scope and level 2/Widespread (F).	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.	
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0 485	Continued From page 1 (a) All assisted living facilities must offer to provide or make available 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 menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. 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 require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that will cause only 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:	0 485		

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	32242	A. BUILDING: _____ B. WING _____	09/18/2025

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0 485	Continued From page 2 During the entrance conference on September 15, 2025, at 11:34 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. On September 15, 2025, at 11:38 a.m., CNS-B stated the licensee provided three meals per day and the cost for the three meals was included in resident services. On page eight of R2's (licensee name) Contract/Lease (assisted living contract) dated June 24, 2022, Section 22: Services Provided Outside (licensee name) indicated the services (licensee name) will/can provide are outline in the UDALSA (Uniform Disclosure of Assisted Living Services and Amenities), service plan, and/or service assessments. R2's Service Plan dated September 16, 2025, indicated food preparation three times daily and three snacks were included in R2's package. Resident assisted living contracts and services lacked an option for residents to opt out of payment for one, two, or three meals residents would not want. On September 16, 2025, at 10:17 a.m., CNS-B stated all residents were charged for three meals per day as part of their services. CNS-B further stated the licensee was not aware a three meals per day charge could not be included as part of the resident's services without allowing an option to opt out of one, two, or three meals a resident would not want. The Minnesota Department of Health Assisted Living Resources and Frequently Asked	0 485		

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0 485	Continued From page 3 Questions (FAQs) website, last updated July 1, 2025, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a TB screen and two-step TST (tuberculin skin test) or other	0 660		

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0 660	Continued From page 4 evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-E). 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: During the entrance conference on September 15, 2025, at 11:34 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by MDH was completed on June 9, 2025, and the facility was determined to be a low risk level. ULP-E was hired on June 17, 2025, to provide direct care services to residents at the assisted living facility. ULP-E's employee record contained a negative TB screen dated March 3, 2025 (106 days prior to ULP-E's employment start date), and a negative two-step TST dated March 3, 2025, and March 10, 2025, respectively, from a previous employer. ULP-E's record lacked a TB screen and two-step TST or other evidence of TB screening such as a	0 660		

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0 660	Continued From page 5 blood draw within 90 days of employment. On September 16, 2025, at 9:05 a.m., CNS-B stated CNS-B had thought the licensee could accept a two-step TST from a previous employer within one year from the employment start date and CNS-B was not aware the employee's two-step TST had to be within 90 days of the employment start date. The licensee's 8.16 TB Screening policy dated August 1, 2021, indicated staff whose essential job functions require work within the same air space of home care [sic] clients will be screen and tested for TB prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs (healthcare workers). New staff will have an IGRA (Interferon-Gamma Release Assay) blood test or a two-step Mantoux (TST) conducted with results documented on the Baseline TB Screening Tool for HCWs. The policy did not address acceptance of an employee's previous TB screening or two-step TST prior to employment. The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test.	0 660		

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0 660	Continued From page 6 The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated July 1, 2025, indicated a licensee could accept a TST dated within 90 days of hire for a new employee. 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 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.	0 680		

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0 680	Continued From page 7 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 15, 2025, at 11:34 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. The licensee's EPP, dated July 2, 2025, lacked the following required content: -quarterly review of the missing resident policy; - development of policies/procedures to address: - procedure for tracking staff and residents; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems); - evacuation plan which included staff responsibilities; - emergency staffing strategies to include	0 680		

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0 680	Continued From page 8 volunteers; and - the facilities role in providing care and treatment at alternative sites under a 1135 waiver; - a communication plan that included: - names and contact information for staff, entities providing services under arrangement, resident physicians, other facilities, volunteers; - arrangement with other facilities; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -must conduct exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP. The licensee's EPP exercises documentation included a power outage dated February 13, 2024, and a Twister tabletop exercise dated July 14, 2025. On September 16, 2025, at 9:46 a.m., CNS-B stated the licensee reviewed the missing resident plan yearly with review of the EPP and was not aware the missing resident plan needed to be reviewed quarterly. CNS-B further stated CNS-B had been working on the development of the licensee's EPP to include all required content, however, the EPP was a work in progress. CNS-B stated CNS-B was aware two exercises to test the EPP were required per year, however, the licensee had only completed one test for 2024. The licensee's 2.28 Missing Resident policy dated August 1, 2021, indicated (licensee name) will review this policy and any individual resident plans that pertain to elopement at least quarterly,	0 680		

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0 680	Continued From page 9 and all changes will be documented. The licensee 9.02 Disaster Planning and Emergency Preparedness policy dated August 21, 2021, indicated (licensee name) will have in place a general EPP, that is in alignment with the facility's requirement to also comply with CMS (Centers for Medicare and Medicaid Services) Appendix Z. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 10 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to comply with Minnesota Fire Code, Minnesota Rules 7511. This had the potential to directly affect four residents and all 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 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: EGRESS WINDOWS OCCUPIED SLEEPING ROOMS On September 16, 2025, at 11:10 a.m., the surveyor toured the facility with director of maintenance (DM)-D and clinical nurse supervisor (CNS)-B. The egress windows in occupied resident sleeping rooms were opened by DM-D and measured by the surveyor. The egress windows in occupied resident sleeping rooms 1, 2, 3, and 4 did not meet the minimum requirements for safe egress. Egress window measurements: Occupied sleeping room 1 - the clear open area of the window measured 17.25 inches width, 43.125 inches height, with a total clear area of	0 775		

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0 775	Continued From page 11 743 square inches. The windowsill height from the floor to the clear opening of the window measured 36 inches. Occupied sleeping room 2 - the clear open area of window 1 measured 18 inches width, 43 inches height, with a total clear area of 774 square inches. The clear open area of the window 2 measured 17.25 inches width, 43.125 inches height, with a total clear area of 743 square inches. The windowsill height from the floor to the clear opening of the window measured 36 inches. Occupied sleeping room 3 - the clear open area of the window measured 16.25 inches width, 31.125 inches height, with a total clear area of 505 square inches. The windowsill height from the floor to the clear opening of the window measured 48 inches. Occupied sleeping room 4 - the clear open area of the window 1 measured 16 inches width, 31.125 inches height, with a total clear area of 498 square inches. The clear open area of the window 2 measured 17.5 inches width, 31.125 inches height, with a total clear area of 544 square inches. The windowsill height from the floor to the clear opening of the window measured 48 inches. During the facility tour interview, DM-D and CNS-B verified the egress window measurements. CNS-B stated the licensee was already aware the egress windows were too small and employees had been completing safety checks and fire watches. Record review indicated employees were conducting fire watches at a frequency of every 15 minutes or every 30 minutes. One window in each resident sleeping room must	0 775		

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0 775	Continued From page 12 meet the minimum window opening size of at least 20 inches in width and, a minimum height of 20 inches, with a total clear area of at least 648 square inches (4.5 square feet). The windowsill height from the floor to the clear opening must be no more than 48 inches. Escape windowsills with clear openings up to 52 inches off the floor may meet the height requirement for existing buildings by securing a step, platform, or bed directly under the window. SMOKE ALARMS The hard wired smoke alarms were discolored indicating the age exceeded 10 years from date of installation. Smoke alarms are required to be maintained with a manufacture date of ten years or less in accordance with MSFC in Minnesota Rules Chapter 7511. EMERGENCY EXIT An exit sign was not posted at the front door. This door was designated as the primary emergency exit on the posted escape floor plan. ELECTRICAL An orange extension cord was attached to the siding on the exterior of the building and used to provide power. During the facility tour interview, DM-D verified the above listed observations. TIME PERIOD FOR CORRECTION: Immediate	0 775		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	0 780		

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0 780	Continued From page 13 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 by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. 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	0 780		

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0 780	Continued From page 14 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 16, 2025, at 11:10 a.m., the surveyor toured the facility with director of maintenance (DM)-D. During the tour the surveyor observed the following: - the smoke alarms installed in the basement were not actuated when DM-D tested the smoke alarms on the main floor - the smoke alarms installed on the main floor were not actuated when DM-D tested the basement smoke alarms - the hardwired smoke alarms installed outside the resident sleeping rooms were not actuated when DM-D tested the wireless battery operated smoke alarms During the facility tour interview, DM-D verified the above listed observations and stated the new wireless smoke alarms were installed in 2022. All smoke alarms installed in the dwelling unit must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=E	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:	0 810		

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0 810	Continued From page 15 (1) location and number of resident sleeping rooms; (2) staff 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) Staff 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 staff 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 observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content and provide required drills.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32242	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTORATION SERVICES OF MN INC	417 MINNESOTA STREET SANDSTONE, MN 55072

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 16 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On September 16, 2025, clinical nurse supervisor (CNS)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN On September 16, 2025, at 11:10 a.m., the surveyor toured the facility with director of maintenance (DM)-D. During the tour, the surveyor observed the following: - Numbers were posted at the doors for each resident room. The posted FSEP floor plans were lacking these resident room number labels. Resident room numbers are required to be included on the FSEP floor plan and correspond with the numbers installed at the resident room doors to provide efficient communication for exiting in the event of a fire or similar emergency. - Windows in the living room, office, and kitchen were labeled as emergency exit routes. During the facility tour interview DM-D stated these windows had not been evaluated to determine if the requirements for egress escape were in compliance. - The door leading into the attached garage from	0 810		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 810	Continued From page 17 the home was inappropriately labeled as an exit on the escape floor plan. Emergency exits are required to lead directly to the exterior of the building and not through a higher-hazard room. During the facility tour interview, DM-D verified the FSEP floor plan required revision. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees at a frequency of every other month evident by fire drill documentation lacking the required frequency. Evacuation drill logs for 2024 and 2025 were provided. Fire drills were not recorded in July or August 2025. During an interview on September 16, 2025, at approximately 12:30 p.m., CNS-B verified the evacuation fire drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction	01290		

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	32242	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01290	Continued From page 18 does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee background study was affiliated with the correct healthcare facility identification (HFID) 32242 of the licensee for five of nine employees (unlicensed personnel (ULP)-C, ULP-F, ULP-G, ULP-H, ULP-I). This had the potential to affect all residents living within 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 15, 2025, at 11:47 a.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of required contents in an employee record. ULP-C ULP-C was hired on July 25, 2017, and began to provide direct care services to residents at the assisted living facility effective August 1, 2021. On September 15, 2025, at 12:16 p.m., the surveyor observed ULP-C administer R2's	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32242	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTORATION SERVICES OF MN INC	417 MINNESOTA STREET SANDSTONE, MN 55072

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01290	Continued From page 19 scheduled noon medications. ULP-C's employee record included a cleared background study dated July 10, 2017, issued by Minnesota (MN) Department of Human Services (DHS) with HFID 1072585. ULP-F ULP-F was hired on July 31, 2023, to provide direct care services to residents at the assisted living facility. ULP-F's employee record included a cleared background study dated July 25, 2023, issued by MN DHS with HFID 1072585. ULP-G ULP-G was hired on January 11, 2023, to provide direct care services to residents at the assisted living facility. Throughout the survey on September 15, 2025, through September 16, 2025, the surveyor observed ULP-G interact with residents at the assisted living facility. ULP-G's employee record included a cleared background study dated January 5, 2023, issued by MN DHS with HFID 1072585. ULP-H ULP-H was hired on January 25, 2022, to provide direct care services to residents at the assisted living facility. On September 16, 2025, at 7:03 a.m., the surveyor observed ULP-H administer R2's scheduled morning medications.	01290		

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	32242	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01290	Continued From page 20 ULP-H's employee record included a cleared background study dated January 19, 2022, issued by MN DHS with HFID 1072585. ULP-I ULP-I was hired on May 8, 2023, to provide direct care services to residents at the assisted living facility. The licensee's schedule dated September 15, 2025, through September 21, 2025, indicated ULP-I was scheduled to work five shifts at the assisted living facility. ULP-I's employee record included a cleared background study dated April 20, 2023, issued by MN DHS with HFID 1072585. ULP-C, ULP-F, ULP-G, ULP-H, and ULP-I's employee records lacked a cleared background study issued by the MN DHS with the licensee's HFID 32242. On September 15, 2025, at 2:28 p.m., the surveyor reviewed the licensee's NETStudy 2.0 Roster HFID 32242 with CNS-B. CNS-B stated ULP-C, ULP-F, ULP-G, ULP-H, and ULP-I were current employees of the licensee and were not listed on the licensee's NETStudy 2.0 Roster. CNS-B further stated licensed assisted living director (LALD)-A or the human resource employee were responsible for submitting employee background checks. On September 16, 2025, at 10:03 a.m. through 10:12 a.m., the surveyor reviewed the licensee's NETStudy 2.0 Roster HFID 32242 with LALD-A. LALD-A searched ULP-C, ULP-F, ULP-G, ULP-H, and ULP-I's names on the NETStudy 2.0	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32242	A. BUILDING: _____ B. WING _____	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTORATION SERVICES OF MN INC	417 MINNESOTA STREET SANDSTONE, MN 55072

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01290	Continued From page 21 website and each search resulted in a cleared background check with the HFID 1072585. LALD-A stated the ULP background studies were submitted under the licensee's sister site HFID and LALD-A would be notified if one of the ULPs background studies were to become ineligible. LALD-A further stated LALD-A was not aware of the requirement to affiliate the ULP background studies to each facility's HFID. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated (licensee name) will conduct a MN DHS background study on all employees and volunteers and contractors at (licensee name) [sic]. The policy did not address background study affiliation. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

RESTORATION SERVICES OF MN INC
417 MINNESOTA STREET
Sandstone, MN 55072
Pine County
Parcel:

Phone:

License Info

License: HFID 32242

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1016251076
Inspection Type: Full - Single
Date: 9/16/2025 Time: 11:30 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

COMMENTS:

DOMESTIC KITCHEN LIMITED TO SAME DAY FOOD PREP/CONSUMPTION

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

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 Duluth District Office inspection report number F1016251076 from 9/16/2025

LACHELLE LUDWIG

Clifford LaVigne,
Public Health Sanitarian 2
218-302-6181
clifford.lavigne@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Establishment Info

RESTORATION SERVICES OF MN INC
Sandstone
County/Group: Pine County

Inspection Info

Report Number: F1016251076
Inspection Type: Full
Date: 9/16/2025
Time: 11:30 AM

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

Food Temperature: Product/Item/Unit: GRAPES**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ALL FOOD FROZEN**; Temperature Process:** Cold-Holding
Location: Upright Freezer at Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: ALL FOOD FROZEN**; Temperature Process:** Cold-Holding
Location: Chest Freezer at Degrees F.
Comment:
Violation Issued?: No

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Sanitizer Observations/Recordings

Establishment Info

RESTORATION SERVICES OF MN INC
Sandstone
County/Group: Pine County

Inspection Info

Report Number: F1016251076
Inspection Type: Full
Date: 9/16/2025
Time: 11:30 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Pre-Soaked Towelettes
Location: Kitchen **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Greater Than** 160 Degrees F.
Comment:
Violation Issued?: No