DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

March 14, 2023

Licensee
Tradition
8500 Tessman Farm Road North
Brooklyn Park, MN 55445

RE: Project Number(s) SL25879015

Dear Licensee:

On February 9, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 1, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-281-9796

JMD

Electronically Delivered

December 29, 2022

Licensee
Tradition
8500 Tessman Farm Road North
Brooklyn Park, MN 55445

RE: Project Number(s) SL25879015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 1, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted no violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents no violations. The Department of Health documents the state licensing correction orders using federal software. Please disregard the heading of the fourth column that states, "Provider's Plan of Correction." A plan of correction is not required.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in

§ 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is

substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

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

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3789 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25879	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITION	8500 TESSMAN FARM ROAD NORTH BROOKLYN PARK, MN 55445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25789015 On November 29, 2022 through December 1, 2022 the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 140 residents; 56 receiving services under the provider's Assisted Living license. On December 1, 2022, the immediacy of correction order 2310 has been removed, however non-compliance remains at a scope and level of I.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care/Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144A.474 subd. 11 (b) (1) (2) -or- 144G.31 subd. 1, 2 and 3	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food	0 480		

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0 480	Continued From page 2 and Beverage Establishment Inspection Report dated November 30, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. 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	0 510		

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0 510	Continued From page 3 situation has occurred only occasionally). The findings include: On November 30, 2022, at 11:00 a.m., the surveyor observed unlicensed personnel (ULP)-E hand sanitized, donned (applied) gloves and set up the glucometer (machine that reads glucose level in blood) to check R6's blood glucose (for diabetes management). The glucometer was not working, so ULP-E left R6's room and came back wearing the same gloves. The surveyor observed a tear in glove on the top side of ULP-E's left hand before leaving the room and upon returning. ULP-E proceeded to check blood glucose with same gloves and without washing hands or hand sanitizing. ULP-E then doffed (removed) gloves and washed hands. ULP-E donned gloves and applied a needle to the Humalog insulin pen and primed (push insulin through to remove air in the needle) the needle and set the ordered dose of 10 units of insulin and injected the medication. After administration, ULP-E doffed gloves and washed hands upon exiting room. GLOVES On November 30, 2022, at 11:20 a.m., ULP-E acknowledged the gloves were not changed upon re-entering the room or hands washed before the blood glucose check. The licensee's Skill Competency Infection Control Techniques dated March 20, 2020, indicated ULP-E was checked off by a registered nurse showing ULP-E was competent on infection control. The Centers for Disease Control and Prevention (CDC) Hand Hygiene Guidance in Health Care Settings last reviewed January 30, 2020, directed	0 510		

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0 510	Continued From page 4	0 510		

health care workers to use an alcohol-based hand rub or wash with soap and water immediately before touching a patient, before moving from work on a soiled body site to a clean body site on the same patient and immediately after glove removal.

INSULIN PEN
On November 30, 2022, at 11:20 a.m., ULP-E indicated they were trained to wipe the insulin pen with alcohol wipe prior to applying the needle. ULP-E realized it wasn't done and acknowledged it was supposed to be done.

The licensee's Competency 14.0d: Medication Administration-Injections form dated March 23, 2022, indicated ULP-E was competent and trained to remove the cap and clean with alcohol prior to connecting the needle to the pen.

On November 30, 2022, at 12:00 p.m., director of nursing (DON)-A and director of clinical services (DOCS)-C stated all ULPs that administer medications are trained to wipe the pen with alcohol prior to connecting the needle. Additionally, they also stated gloves should have been changed after leaving the room and returning to perform a task.

The licensee's Infection Control policy dated August 12, 2015, indicated hand washing would be performed by all staff after removing gloves or any other personal protective equipment (PPE) such as gloves, gowns, masks, or protective eyewear.

The licensee's 6.07 Standard Precautions policy dated June 21, 2021, indicated staff will change gloves between tasks and procedures on the same resident after contact with material that

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0 510	Continued From page 5 may contain a high concentration of microorganisms. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced	0 680		

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0 680	Continued From page 6 by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 29, 2022, at 11:00 a.m., during the entrance conference, the surveyor requested to review the licensee's emergency preparedness plan (EPP). During a facility tour on November 29, 2022, at 11:30 a.m., the surveyor did not observe a posting of the licensee's EPP. The licensee lacked evidence of the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during	0 680		

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0 680	Continued From page 7 emergency situation; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On December 1, 2022, at 11:00 a.m., licensed assisted living director (LALD)-D stated she was familiar with Appendix Z which is part of the EPP. LALD-D verified the EPP lacked required content. LALD-D also stated the licensee is working on updating the EPP. Director of clinical services (DOCS)-C stated the EPP used to be posted in the common area on the wall, but it was located in the LALD's office at the time of the survey. The licensee's 7.01 Disaster Planning and Emergency Preparedness Plan policy dated April 23, 2021, indicated the EPP would include the above information but did not specify it should be located in a conspicuous area.	0 680		

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0 680	Continued From page 8 No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the	0 730		

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0 730	Continued From page 9 appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident records included a discharge summary with the required content for one of two discharged residents (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 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: R1 began receiving services on March 26, 2022, and was discharged on October 10, 2022. R1's diagnoses included history of falling, displaced fracture of base of neck of right femur (thigh bone), and hypertension (high blood	0 730		

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0 730	Continued From page 10 pressure). R1's unlabeled medical document dated July 18, 2022, indicated R1 received services including reminders to use walker and toileting assistance. R1's record lacked evidence a discharge summary was completed. On December 1, 2022, at 12:00 p.m., director of clinical services (DOCS)-C indicated the licensee did not complete a discharge summary for R1. The licensee's Discharge Summary policy dated August 1, 2021, indicated a discharge summary would be written by the time of discharge and provided to the resident at the time of discharge. The discharge summary would include a summary of the resident's stay, reconciliation of all pre discharged medications with post discharged prescribed and over-the-counter medications, and post discharge plan developed with the resident or the resident's representatives. No further information was provided. TIME PERIOD FOR CORRECTIONS: Twenty-one (21) days	0 730		
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	0 780		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITION	8500 TESSMAN FARM ROAD NORTH BROOKLYN PARK, MN 55445

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 780	Continued From page 11 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 a working smoke alarm inside the sleeping room of resident unit 249 and the interconnection requirement of the smoke alarms in resident unit 245. This has the potential to directly affect residents receiving care in those units. 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 November 30, 2022, approximately from	0 780		

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0 780	Continued From page 12 11:20 a.m. to 1:30 p.m. survey staff toured the facility with the regional maintenance director (RMD)-F and the licensed assisted living director (LALD)-D. During the tour, survey staff observed and the RMD-F verified the following findings when the smoke alarms were tested: 1) In the one-bedroom resident unit 249, the smoke alarm located inside the sleeping room failed to sound when the RMD-F tested the smoke alarms. 2) In the one-bedroom living unit 245, the smoke alarms were not interconnected as required. The finding was evident as the DM-H tested the smoke alarms in unit 245 and each alarm sounded local and failed to sound the other smoke alarm for proper notification. On November 30, 2022, at approximately 2:45 p.m., during the exit interview, the RMD-F and the LALD-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and	0 800		

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0 800	Continued From page 13 operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). On November 30, 2022, approximately from 11:20 a.m. to 1:30 p.m. survey staff toured the facility with the regional maintenance director (RMD)-F and the licensed assisted living director (LALD)-D. During the tour, survey staff observed and the RMD-F verified the following: 1) Inside the 3rd-floor mechanical room, the furnace filter was layered with dust and needed to be cleaned. 2) In Resident living unit 225, the light fixtures above the kitchen area failed to work when the switch was turned on. 3) The fire-rated doors serving the 3rd-floor elevator, the garage level elevator, and the 1st-floor trash/recycle room failed to latch positively when closed. 4) Two of the five water heaters located on the garage level were not in working order. One water heater had a "hardware failure" error and one had a "blocked exhaust" error electronically noted on the units. The RMD-F stated that the contractor was currently working on the repair. 5) A small pipe leak near the booster water pump near the water heater location. 6) The reduced pressure zone assembly device (RPZ) serving the lawn irrigation system located in the sprinkler riser room (garage level) was	0 800		

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0 800	Continued From page 14 tagged with the last test date, April 30, 2020. The RPZ backflow preventer must be annually tested for proper performance by a qualified backflow tester to protect the building water supply system from cross-connection. On November 30, 2022, at approximately 2:45 p.m., during the exit interview, the RMD-F and the LALD-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in	0 810		

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0 810	Continued From page 15 their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on the documentation review and interview, the licensee failed to provide the complete content of the fire safety and evacuation plan, the minimum required employee evacuation drills, and the minimum required staff and resident training on fire safety and evacuation. This has the potential to directly affect the safety of staff and all residents receiving care. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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 November 30, 2022, at approximately 1:30 p.m., survey staff received the facility fire safety and evacuation plan and related documentation for review from the regional maintenance director (RMD)-F and the licensed assisted living director (LALD)-D. Document review indicated the	0 810		

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0 810	Continued From page 16 following findings: 1) The plan documentation lacked procedures necessary for addressing resident movement, evacuation, and relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. Unique resident needs during emergency movement or an evacuation may be residents who have mobility limitations, cognitive impairment, visual/hearing impairment, or any residents needing assistance during an evacuation and must be addressed in the fire safety and evacuation plan documentation. The LALD-D verified the finding after further looking into her computer for additional electronic documentation. In addition, the RMD-F asked for clarification relating to the order of evacuation of residents specific to their unique needs or those needing additional assistance. 2) Documentation review showed the licensee lacked a record of employee training specifically on the fire safety and evacuation plan for the facility. Employee training record on fire safety and evacuation was requested but no record was provided for review. Survey staff explained to the LALD-D that the minimum required employee training is upon hire and twice a year for fire safety and evacuation. 3) Documentation review indicated that the licensee did not provide annual training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation. Resident training record for fire safety and evacuation was requested but was not available. 4)The drill record review indicated an insufficient number of employee fire safety and evacuation drills performed to date. One fire drill record was provided for review dated, October 12, 2022, with	0 810		

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0 810	Continued From page 17 no time specified. The RMD-F explained they had a few turnovers of maintenance staff and he was not able to locate any other records from the previous staff. Survey staff explained to the RMD-F that fire and similar emergency evacuation drills must be performed to ensure all employees are prepared to carry evacuation as required. Fire and evacuation drills may be performed at the same time and recorded as such. On November 30, 2022, at approximately 2:45 p.m., during the exit interview, the RMD-F and the LALD-D acknowledged the above findings. No further information was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date	01060		

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01060	Continued From page 18 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care of the emergency relocation greater than four days for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01060		

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01060	Continued From page 19	01060		

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:

R4's Progress Notes dated November 1, 2022, at 10:33 a.m., indicated R4 had an emergency relocation to North Memorial Hospital as R4 was unable to safely be transferred with assist of two people, as resident cannot bear weight.

R4's Progress Notes dated November 14, 2022, at 8:27 p.m., indicated R4 was admitted to a transitional care unit (TCU) (nursing facility that offers physical and occupational therapy and twenty-four-hour nursing care) to start physical and occupational therapy. R4's anticipated discharge date was November 20, 2022.

R4's Progress Notes dated November 28, 2022, at 2:40 p.m., indicated R4 was still at the TCU and did not have a discharge date available.

R4's record lacked a written notice with the required statutory content was provided to resident or to the OOLTC as noted below;
In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:
(1) the reason for the relocation;
(2) the name and contact information for the location to which the resident has been relocated and any new service provider;
(3) contact information for the Office of Ombudsman for Long-Term Care;
(4) if known and applicable, the approximate date

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01060	Continued From page 20 or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. On December 1, 2022, at 11:08 a.m., director of clinical services (DOCS)-C acknowledged R4's record lacked the required written notice and the OOLTC was not provided a copy of the notice when R4 did not return to the facility within four (4) days. DOCS-C thought the written notice was only required if the resident was being discharged or terminated from the facility. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		

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01760	Continued From page 21	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as prescribed for one of three residents (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On November 30, 2022, at 11:40 a.m. unlicensed personnel (ULP)-B administered noon medications (eye drops) to R7. ULP-B	01760		

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01760	Continued From page 22	01760		

administered one drop of Genteal Tears to R7's right eye. After ULP-B waited the appropriate amount of time, ULP-B administered prednisolone (eye drops) to R7's right eye. The surveyor observed two drops went into right eye (drops were milky white and was visibly seen).

R7 admitted to licensee on May 25, 2016.

R7's diagnoses included glaucoma, major depressive disorder, and achalasia of cardia (swallowing disorder).

R7's prescriber's orders dated January 10, 2022, included an order for prednisolone 1% eye drop, one drop to right eye two times a day.

During an interview on November 30, 2022, at 11:45 a.m. ULP-B didn't realize two drops went into R7's right eye but acknowledged the order was for one drop.

ULP-B's Skill Competency Medication Administration-Routes form dated April 17, 2020, indicated ULP-B was deemed competent to administer eye drops by a registered nurse.

ULP-B's Checklist for Medication Administration form dated the following dates: September 2019, September 20, 2019, and September 27, 2019, signed by a nurse indicated ULP-B was competent to provide medication administration.

On November 30, 2022, at 12:00 p.m., director of nursing (DON)-A and director of clinical services (DOCS)-C were informed of the medication error and acknowledged what happened was considered a medication error.

The licensee's 5.10 Medication Management

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01760	Continued From page 23 Services Provided by Unlicensed Personnel policy dated January 20, 2022, indicated a registered nurse (RN) would instruct the ULP to check the resident's medication administration record (EMAR) prior to medication administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for two of two residents (R3, R4) who utilized bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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:	02310		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 24 R3 On November 30, 2022, at approximately 9:00 a.m., the surveyors observed a bilateral (both) side rail on R3's hospital bed. R3 admitted on November 18, 2022, with diagnoses including type 2 diabetes, muscle weakness, and hypotension. R3's Minnesota AL Comprehensive/Quarterly/14 Day Assessment - V3 dated November 23, 2022, indicated R3 required one person assist for mobility on a routine basis, medication administration, blood sugar monitoring, and utilized a two wheeled walker. R3's Service Plan dated November 18, 2022, indicated R3 received services including medication management, type 2 diabetes management, and assistance with transfers. R3's medical record lacked documentation of a side rail assessment and education of the risks and benefits associated with the use of side rails. R4 On November 30, 2022, at approximately 9:10 a.m., the surveyors observed R4's bed had a siderail on the right side, which was not attached to the bed. The siderail was an upside down "U" shape with rails proceeding between the mattress and box spring. The surveyor grasped the siderail and noted the siderail was not secured to the bed and did move when pulled and pushed on with force. R4 admitted on February 14, 2020, with diagnoses including depression, unspecified abnormalities of gait and mobility, and fracture of	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25879	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITION	8500 TESSMAN FARM ROAD NORTH BROOKLYN PARK, MN 55445

(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
02310	Continued From page 25 shaft of humerus. R4's Minnesota AL Comprehensive/Quarterly/14 Day Assessment - V3 dated September 16, 2022, indicated R3 needed assistance with activity of daily living (ADLs), and medication assistance three times daily. R4's Service Plan dated November 29, 2021, indicated R3 received services including medication management, and unlicensed personnel (ULPs) to assist R3 in and out of bed. R4's medical record lacked documentation of a side rail assessment and education of the risks and benefits associated with the use of siderail. On November 30, 2022, at approximately 9:30 a.m., director of nursing (DON)-A acknowledged side rails are in place for R3 and R4. DON-A stated consumer siderails are provided by residents' family members, the licensee does not provide siderails. DON-A indicated residents' family members were responsible for installing the siderails. DON-A was unaware if there were manufacturer's installation instructions available. The licensee's Side rails policy dated August 1, 2021, indicated "When siderails are in use, the RN shall conduct an assessment to identify the intended purpose of the siderail and the risks regarding the use of the siderail. Staff shall determine if the siderail is considered to be safe. "Safe" shall be defined as meeting all of the requirements listed below: a. The siderail is used consistent with manufacturer's directions. Be aware of siderails that slide between the mattress and box spring designed for toddler use. b. Nurse will get a doctor's order for the use of	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25879	A. BUILDING: _____ B. WING _____	12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRADITION	8500 TESSMAN FARM ROAD NORTH BROOKLYN PARK, MN 55445

(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
02310	Continued From page 26 the siderail. c. Nurse will conduct a quarterly safety function of the siderail or any other mechanical device and review the risk and benefit of the mechanical device. d. Staff will be trained on hire, annually, and as needed on the function of the siderail or mechanical device. e. The siderails are installed securely and maintained in good operating condition. Be aware of "wobbly" siderails. f. The siderail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means siderail zones 1,2, and 3 must not exceed 4.75., and the resident and, when appropriate, the resident's representative, shall be informed of the risks and benefits regarding the use of siderails. Such education shall be documented in the resident Record." TIME PERIOD FOR CORRECTION: Immediate Immediacy is removed as confirmed by review by evaluation supervisor on December 1, 2022, however noncompliance remains at a scope and severity of I. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

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

Type: Full
Date: *11/30/22*
Time: 13:11:42
Report: 1021221382

Food and Beverage Establishment Inspection Report

Location:
Tradition
8500 Tessman Farm Road North
Brooklyn Park, MN55445
Hennepin County, 27

Establishment Info:
ID #: 0038653
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7634167740
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

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

FINAL UTENSIL SURFACE TEMPERATURE AT DISH MACHINE MEASURED 152F. KITCHEN STAFF ALREADY HAD THEIR 3 COMPARTMENT SINK SET UP. STAFF CAN WASH IN DISH MACHINE BUT THEY NEED TO MANUALLY SANITIZE DISHES/UTENSILS IN THE 3 COMPARTMENT SINK. SEE COMMENTS.

Comply By: 11/30/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN HIGH TEMPERATURE DISH MACHINE. PROVIDE.

Comply By: 12/07/22

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to

preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.

INSIDE TOP PART OF THE ICE MACHINE CONTAINS ACCUMULATION OF DEBRIS. CLEAN AND SANITIZE ICE MACHINE.

Comply By: 12/02/22

4-900 Protecting Clean Items

4-903.11B

MN Rule 4626.0955B Store all clean equipment and utensils in a self-draining position that permits air drying, and covered or inverted.

STAFF PLACING CLOTH TOWELS UNDER A PLASTIC RACK NEXT TO THE SANITIZING COMPARTMENT IN THE 3 COMPARTMENT SINK. THEY USE THE RACK TO PLACE WET DISHES AND UTENSILS. STAFF REMOVED TOWELS DURING INSPECTION. CORRECTED ON-SITE. SEE COMMENTS.

Comply By: 11/30/22

Surface and Equipment Sanitizers

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

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: THREE COMPARTMENT SINK
Violation Issued: No

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

Final Utensil Surface Temp: = at 152 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 179 Degrees Fahrenheit - Location: COOKED SHRIMP - HOT WELLS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 187 Degrees Fahrenheit - Location: QUINOA - HOT WELLS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 192 Degrees Fahrenheit - Location: VEGGIES - HOT WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: SLICED TOMATO - PREP COOLER, COLD WELLS
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: SLICED TURKEY HAM - PREP COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: SHREDDED CHEESE - PREP COOLER
Violation Issued: No

Process/Item: Cooking
Temperature: 198 Degrees Fahrenheit - Location: TACO MEAT - STOVE
Violation Issued: No

Process/Item: Hot Holding
Temperature: 177 Degrees Fahrenheit - Location: LEMON & GARLIC SAUCE - STOVE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: CUT MELON - WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: RAW GROUND BEEF - WALK-IN COOLER
Violation Issued: No

Process/Item: Thawing
Temperature: 30 Degrees Fahrenheit - Location: RAW SALMON - WALK-IN COOLER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 183 Degrees Fahrenheit - Location: BROCCOLI CHEDDAR SOUP - SOUP WELL
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK - ARCTIC AIR UPRIGHT COOLER
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH CULINARY DIRECTOR, JASMINE BOWE AND HEALTH REGULATION DIVISION NURSE
EVALUATORS, ANNA BOHNEN AND SAFIA HASSAN.

CONTINUATION OF MN Rule 4626.0905B
PER CONVERSATION WITH JASMINE, THEY ALREADY CALLED SOMEONE TO SERVICE THE DISH MACHINE. THEY ARE WAITING FOR A PART. STAFF NEED TO MANUALLY SANITIZE ALL DISHES AND UTENSILS IN THE THREE COMPARTMENT SINK UNTIL DISH MACHINE IS ABLE TO REACH A FINAL UTENSIL SURFACE TEMPERATURE OF 160F OR ABOVE.

CONTINAUTION OF MN Rule 4626.0955B
CLOTH TOWELS ARE ABSORBENT. DISCUSSED WITH STAFF THAT ONCE TOWELS ARE WET, THEY NEED TO BE STORED IN APPROVED SANITIZING SOLUTION.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021221382 of 11/30/22.

Certified Food Protection Manager: JASMINE L. BOWE

Certification Number: FM64627 Expires: 05/11/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

JASMINE BOWE
CULINARY DIRECTOR

Signed: _____

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us