Electronically Delivered

February 9, 2024

Licensee
Recovery Home Health Care
717 Terrace Drive
Roseville, MN  55113

RE:  Project Number(s) SL36727015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 18, 2024, 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.

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

**STATE CORRECTION ORDERS**
The enclosed State Form documents the state correction orders. 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**

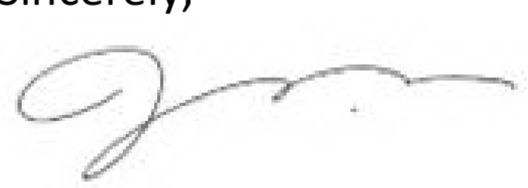
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days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

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

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,



Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36727 | A. BUILDING: _____ B. WING _____ | 01/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| RECOVERY HOME HEALTH CARE | 717 TERRACE DRIVE ROSEVILLE, MN 55113 |

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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL#36727015<br><br>On January 16, 2024, through January 18, 2024, 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 3 active residents; 3 receiving services under the Assisted Living license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 16, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 570 SS=C | 144G.42 Subdivision 1 Display of license<br><br>The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to | 0 570 | | |

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| 0 570 | Continued From page 2<br>any person who requests it.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to display the original current license at the main entrance as required.<br><br>This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On January 16, 2024, at approximately 10:00 a.m., upon entering the facility, the surveyor noted the license was not posted at the facility entrance as required.<br><br>On January 16, 2024, at approximately 10:45 a.m., during the facility tour with licensed assisted living director (LALD)-A, the surveyor observed the license was not posted in the facility.<br><br>On January 16, 2024, at 10:50 a.m., LALD-A stated the license was stored in the office and was unaware of the license posting requirement.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 570 | | |

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| 0 680 | Continued From page 3 | 0 680 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a | 0 680 | | |

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| 0 680 | Continued From page 4<br><br>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).<br><br>The findings include:<br><br>On January 16, 2024, at approximately 10:55 a.m., licensed assisted living director (LALD)-A provided a binder and indicated the contents were the licensee's EPP.<br><br>The licensee's EPP dated January 14, 2024, lacked documentation including all the required elements of a EPP training and testing program with conducted exercises to test the emergency plan annually by participating in a full-scale exercise that is community-based.<br><br>On January 16, 2024, at approximately 2:50 p.m., licensed assisted living director (LALD)-A stated a tabletop exercise was performed in 2023, but not a full-scale exercise and was unaware of the requirement.<br><br>The licensee's 9.01 Emergency Preparedness policy dated February 23, 2022, indicated the licensee would have an identified EPP in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION:<br>Twenty-One (21) days | 0 680 | | |

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| 0 780 | Continued From page 5 | 0 780 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a | 0 780 | | |

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| 0 780 | Continued From page 6<br><br>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).<br><br>The findings include:<br><br>On January 16, 2024, at 11:15 a.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed the following:<br>1. A smoke alarm was not installed outside and in the immediate vicinity of the bedroom on the upper level of the home.<br>2. When smoke alarms were tested, none of the other smoke alarms in the dwelling unit were activated. The smoke alarms were not interconnected.<br><br>During an interview on January 17, 2024, at 1:30 p.m., LALD-A verified a smoke alarm was not provided outside the upper-level bedroom and smoke alarms were not interconnected. LALD-A stated this would be corrected.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 780 | | |
| 0 790 SS=F | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, | 0 790 | | |

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| 0 790 | Continued From page 7<br><br>located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to install and maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On January 16, 2024, at 11:15 a.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed the following:<br>1. Tags or labels were not attached to the portable fire extinguishers showing annual maintenance had been performed by certified service personnel.<br>2. Tags or labels were not attached to the portable fire extinguishers showing monthly inspections had been completed. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, | 0 790 | | |

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| 0 790 | Continued From page 8<br><br>and there is no obvious physical damage or condition that would interfere with its use or operation.<br>3. Both upper-level fire extinguishers were not mounted. One of these fire extinguishers was sitting on a staircase ledge. Fire extinguishers must be properly installed and mounted at least 12 inches above the floor to prevent them from being moved or damaged.<br>4. A portable fire extinguisher was not installed for the lower level of the home. Portable fire extinguishers must be located so the travel distance to the nearest fire extinguisher does not exceed 75 feet.<br><br>During an interview on January 17, 2024, at 1:30 p.m., LALD-A verified annual maintenance and monthly inspections had not been performed on the fire extinguishers. LALD-A verified the fire extinguishers were not properly installed and the travel distance from the current fire extinguisher locations to the lower level exceeded 75 feet. LALD-A stated the licensee would relocate one of the upper-level fire extinguishers to the lower level and properly install both of them. The LALD-A explained the licensee was not aware of the annual maintenance and monthly inspection requirements.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 790 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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 | 0 800 | | |

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| 0 800 | Continued From page 9<br>health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On January 16, 2024, at 11:15 a.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed an exit sign posted over the door leading into the garage from the home. This door was also labeled as an emergency exit on the evacuation diagram. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room.<br><br>During an interview on January 17, 2024, at 1:00 p.m., LALD-A verified the door leading into the garage was designated as an emergency exit. LALD-A stated the exit sign would be removed and the evacuation diagram revised. | 0 800 | | |

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| 0 800 | Continued From page 10<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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. | 0 810 | | |

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| 0 810 | Continued From page 11<br><br>This MN Requirement is not met as evidenced by:<br>Based on record review and interview, the licensee failed to develop fire safety and evacuation plans with the required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors.<br><br>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 potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>On January 17, 2024, the licensee provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN<br>The FSEP included a fire safety policy dated February 23, 2022. This policy was a template and had not been developed for use at the facility.<br><br>The employee actions in the FSEP inappropriately direct employees to generally plan to shelter in place and the fire department will give orders on whether or not to evacuate.<br><br>The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36727 | A. BUILDING: _____ B. WING _____ | 01/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RECOVERY HOME HEALTH CARE | 717 TERRACE DRIVE ROSEVILLE, MN 55113 |

| (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 12<br><br>similar emergency relative to the facility's building layout and environmental risks. The employee actions for fire were limited to the acronyms RACE (Remove, Alarm, Confine, and Extinguish or Evacuate) and PASS (Pull, Aim, Squeeze, Sweep).<br><br>The FSEP did not identify specific fire protection procedures for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included.<br><br>The FSEP directs employees to evacuate residents from the building but fails to include information on where residents should relocate to in the event of a fire.<br><br>The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.<br><br>During an interview on January 17, 2024, at 1:30 p.m., LALD-A verified the FSEP was a template and had not been developed for use at this facility.<br><br>TRAINING<br>Record review indicated the licensee failed to provide training to employees on the FSEP upon hire as evident by inappropriate training documentation. An EduCare training record was provided as documentation of FSEP training for a new hire employee. The third-party training provided at hire was not specific to the facility FSEP. | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 36727 | A. BUILDING: _____ B. WING _____ | 01/18/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RECOVERY HOME HEALTH CARE | 717 TERRACE DRIVE ROSEVILLE, MN 55113 |

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|---|---|---|---|---|
| 0 810 | Continued From page 13<br><br>During an interview with survey staff on January 17, 2024, at 1:30 p.m., LALD-A verified employee training records were not available to support FSEP training had been completed at the time of hire. LALD-A verified EduCare training was completed at the time of hire during orientation.<br><br>DRILLS<br>Record review indicated the licensee failed to conduct employee evacuation drills twice per year, per shift with at least one evacuation drill every other month as evident by no fire drill records for January, February, March, May, June, August, and September 2023. Eight fire drills were recorded on the 2023 log, these drills were completed in April, July, October, and November.<br><br>During an interview on January 17, 2024, at 1:30 p.m., LALD-A verified fire drills were not performed at a frequency of every other month. LALD-A stated the fire drill frequency will be revised to every other month.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |

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

Type: Full
Date: *01/16/24*
Time: 09:07:28
Report: 8058241011

# Food and Beverage Establishment Inspection Report



**Location:**
Recovery Home Health Care
717 Terrace Drive
Roseville, MN55113
Ramsey County, 62

**Establishment Info:**
ID #: 0038356
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 9522126802
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.

**4-600 Cleaning Equipment and Utensils**

***4-601.11C***

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

LARGE AMOUNTS OF GREASE HAVE BUILT UP ABOVE THE MICROWAVE - INCLUDES THE MICROWAVE, CABINETS, WALL, FAN BLADES AND CEILING - CLEAN AND ENSURE MICROWAVE IS CONNECTED TO VENT

*Comply By: 02/16/24*

**Surface and Equipment Sanitizers**

Hot Water: = at 180 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

**Food and Equipment Temperatures**

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

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

Process/Item: LASAGNA
Temperature: COOLER Degrees Fahrenheit - Location: 40
Violation Issued: No

Type: Full
Date: *01/16/24*
Time: 09:07:28
Report: 8058241011
Recovery Home Health Care

# Food and Beverage Establishment Inspection Report

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

HRD INSPECTOR: CARL SAMROCK
ESTABLISHMENT PIC: ABDUKADIR M NOR

ESTABLISHMENT IS SINGLE FAMILY HOME IN RESIDENTIAL NEIGHBORHOOD. FINISHES AND EQUIPMENT ARE NON-COMMERCIAL.

**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 8058241011 of 01/16/24.

Certified Food Protection Manager: ABDUKADIR M NOR

Certification Number: 107981 Expires: 08/01/24

**Inspection report reviewed with person in charge and emailed.**

Signed: _____
ABDUKADIR M NOR
PIC

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