Electronically Delivered

August 29, 2023

Licensee
Beacon Hill
5300 Beacon Hill Road
Minnetonka, MN 55345

RE: Project Number(s) SL20025015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 22, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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 and enforcement actions 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

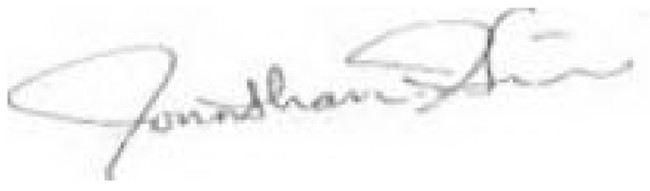
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,



Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

JMD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 20025 | A. BUILDING: _____ B. WING _____ | 08/22/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<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>SL20025015-0<br><br>On August 21, 2023, through August 22, 2023, 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 38 active residents; all of whom were receiving services under the Assisted Living with Dementia Care license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living with Dementia Care 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.<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 subd. 1, 2, and 3. | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>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 included document titled, Food and Beverage Establishment Inspection Report dated August 21, 2023, for the specific Minnesota Food Code deficiencies.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |
| 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 health, safety, comfort, and well-being of the | 0 800 | | |

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| 0 800 | Continued From page 2<br><br>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 maintain 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 and staff.<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 August 21, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Environment Services Director (ESD)-C. During the facility tour, survey staff observed the following:<br><br>In the fitness room on the third floor, it was observed that extensive mold or similar black substance was on the supply air grille and adjacent gypsum ceiling. Mold in the room housed by air distribution equipment has the potential to circulate mold throughout the floor served by that equipment.<br><br>In the dining room on the first floor, it was observed that mold or a similar black substance | 0 800 | | |

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| 0 800 | Continued From page 3<br><br>was on the supply air grille. Mold in the room housed by air distribution equipment has the potential to circulate mold throughout the floor served by that equipment. It was observed that there was a considerable brown stain on the acoustic ceiling tile by window with evidence of condensation.<br><br>In the dining room by big table on the first floor, it was observed that the 2'x4' patterned acoustic ceiling tiles were sagging low in the middle and had a risk of s falling out of the ceiling grid.<br><br>This deficient condition was visually verified by ESD-C accompanying the tour.<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 | 0 810 | | |

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| 0 810 | Continued From page 4<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to conduct required evacuation drills every other month. This had the potential to affect all staff, residents, 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, 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).<br><br>Findings include:<br><br>An interview and record review were conducted on August 21, 2023, at approximately 1:00 p.m. with the Licensed Assisted Living Director (LALD)-A and Environment Services Director | 0 810 | | |

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| 0 810 | Continued From page 5<br><br>(ESD)-C on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility.<br><br>Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Review of the provided documented drills indicated that the licensee had conducted fire drills on 10/12/22 at 9:25 am., 10/18/22 at 7:00 am., 10/20/22 at 7:00 am., 1/23/23 at 9:40 am., 6/22/23 at 1:47 pm., 7/6/12 at 3:20 pm. Provided documentation indicated that the facility failed to provide evacuation drills every other month and failed to provide two drills for the third shift. ESD-C verified that no further drills were conducted besides those provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 01530 SS=D | 144G.64 TRAINING IN DEMENTIA CARE REQUIRED<br><br>(a) All assisted living facilities must meet the following training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter;<br>(2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not | 01530 | | |

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| 01530 | Continued From page 6<br><br>provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for one of two employees (unlicensed personnel (ULP)-E).<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 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).<br><br>The findings include:<br><br>The licensee had an assisted living facility license, effective August 1, 2021.<br><br>ULP-E was hired on May 18, 2023, and provided direct care services to the residents of the facility.<br><br>On August 22, 2023, at 7:45 a.m., ULP-E was | 01530 | | |

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| 01530 | Continued From page 7<br><br>observed to assist R4 with compression stockings, and medication administration.<br><br>ULP-E's employee record lacked documentation of eight hours of dementia care training completed within 160 working hours of the employment start date.<br><br>On August 22, 2023, at 11:47 a.m., clinical nurse supervisor (CNS)-B stated "yes, it looks like ULP-E has not completed all of the assigned initial dementia care training."<br>-2:30 p.m. CNS-B indicated again that ULP-E lacked the 8 hours of dementia care that is required within 160 hours of employment start date.<br><br>The licensee's Dementia Training policy dated August 1, 2021, included "[Licensee] provides specialized training in the area of Alzheimer's Disease and Related Disorders to its employees that also meet regulatory requirements and timelines." In addition, included:<br>1) Initial Orientation, a)Dementia training will include:<br>i) An explanation of Alzheimer's disease and other dementias;<br>ii) Assistance with activities of daily living;<br>iii) Problem solving with challenging behaviors;<br>iv) Communication Skills; and<br>v) Person-centered planning and service delivery.<br>2) Employees who have not completed their initial dementia care training will not provide direct care independently:<br>a) There will be another employee onsite while this employee is working who:<br>i) Has completed the initial eight hours of training on topics related to dementia care; | 01530 | | |

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| 01530 | Continued From page 8<br><br>ii) Will serve as a resource for the employee who has not completed all of the initial dementia care training; and b) A trainer or supervisor will be available for consultation with the new employee until the training requirement is complete."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530 | | |
| 01620 SS=D | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.<br>(d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.<br>(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. | 01620 | | |

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| 01620 | Continued From page 9<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, no more than 14 days after admission for one of three residents (R2).<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 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).<br><br>The findings include:<br><br>14-DAY<br><br>R2 was admitted June 6, 2022, and received services including assistance with meals, housekeeping, laundry, showers, and medication administration.<br><br>R2's record included an initial comprehensive nursing assessment, dated May 23, 2022, and a subsequent RN comprehensive nursing assessment, dated June 29, 2022, 37 days after the start of services. R2's 14-day RN comprehensive nursing assessment was completed 23 days late.<br><br>On August 21, 2023, at 12:15 p.m., surveyor interviewed R2 on the nursing services she received from the licensee. R2 indicated the nurses at the facility assisted her with medication, and visited her after she came back from the | 01620 | | |

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| 01620 | Continued From page 10<br>hospital this week.<br><br>On August 22, 2023, at 11:47 a.m., clinical nurse supervisor (CNS)-B was interviewed about the overdue 14-day RN comprehensive nursing assessment. CNS-B stated she would check in the electronic medial record.<br>-2:30 p.m., CNS-B and licensed assisted living director (LALD)-A stated there was a different clinical nurse supervisor employed here during that time, and indicated it was not completed on time.<br><br>The licensee's MN (Minnesota) AL (assisted living) Nursing Assessment policy updated May 3, 2022, indicated "7. An RN will complete the following comprehensive nursing assessments of the resident's physical, mental, and cognitive needs as required:<br>a. Initial Assessment;<br>b. 14-day assessment, completed up to 14-days after start of services and will include:<br>i. An evaluation of the resident's medication management services and the resident's medications and complete a medication management plan if the organization provides services related to the resident's medications;<br>ii. An evaluation of the resident's treatments, if any and complete the treatment and therapy management plan if the organization provides services related to the resident's treatments;<br>iii. Communication of any new problems or concerns to the resident's physician or health care providers;<br>c. Ongoing assessment: completed periodically but no less than every 90-days; and<br>d. Change in resident condition."<br><br>No additional information was provided. | 01620 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BEACON HILL | 5300 BEACON HILL ROAD MINNETONKA, MN 55345 |

| (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 |
|---|---|---|---|---|
| 01620 | Continued From page 11<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |

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

Type: Full
Date: *08/21/23*
Time: 13:00:00
Report: 8041231250

# Food and Beverage Establishment Inspection Report



**Location:**
Beacon Hill
5300 Beacon Hill Road
Minnetonka, MN55345
Hennepin County, 27

**Establishment Info:**
ID #: 0037616
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 9529888800
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.

**3-500B Microbial Control: hot and cold holding**

***3-501.16A2*** ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

PREP COOLER: SLICED CHEESE AT 43F, DELI HAM AT 45F. HAM WAS DISCARDED. DISCUSSED REMOVING DELI MEATS FROM DOUBLE BAGS, NOT OVERFILLING CONTAINERS AND USE OF LIDS TO MAINTAIN FOOD AT PROPER TEMPERATURE.

*Comply By: 08/21/23*

**3-700 Contaminated Food: discarded**

***3-701.11A*** ***** Priority 1 *****

MN Rule 4626.0445A Discard or recondition food that is unsafe, adulterated or not honestly presented.

CUT TOMATO IN THE PREP COOLER ON THE COOKLINE HAD MOLD ON IT. TOMATO WAS DISCARDED DURING INSPECTION.

*Comply By: 08/21/23*

**4-300 Equipment Numbers and Capacities**

***4-302.14*** ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

TEST KIT FOR THE PRODUCE WASH IS EXPIRED.

*Comply By: 09/04/23*

**7-100 Toxic Labeling**

***7-102.11*** ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

TWO SPRAY BOTTLES OF SANITIZER SOLUTION IN THE FRONT FOOD SERVICE AREA WERE NOT LABELED AT TIME OF INSPECTION. CORRECTED ON SITE.

*Comply By: 08/21/23*

**4-500 Equipment Maintenance and Operation**

***4-501.11AB***

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

OBSERVED WATER ACCUMULATION ON THE BOTTOM OF THE PREP COOLER ON THE COOKLINE. ADJUST/REPAIR AS NEEDED.

*Comply By: 08/28/23*

**Surface and Equipment Sanitizers**

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: sani dispenser
Violation Issued: No

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Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: sanitizer bucket- cookline
Violation Issued: No

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Utensil Surface Temp.: = at 164 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: prep cooler: cut melon
Violation Issued: No

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Process/Item: Cold Holding
Temperature: 45 Degrees Fahrenheit - Location: prep cooler: ham
Violation Issued: Yes

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Process/Item: Cold Holding
Temperature: 43 Degrees Fahrenheit - Location: prep cooler: sliced cheese
Violation Issued: Yes

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Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: walk-in cooler: coleslaw
Violation Issued: No

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Process/Item: Cooling
Temperature: 60 Degrees Fahrenheit - Location: walk-in cooler: pulled pork (1 hour cooling)
Violation Issued: No

Type: Full
Date: *08/21/23*
Time: 13:00:00
Report: 8041231250
Beacon Hill

# Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: 2 door cooler: ambient air temp.
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: reach-in cooler/front: milk
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: walk-in cooler: chicken
Violation Issued: No

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

Inspection was completed with Drew Swanson (Culinary Director) and Blia Lor (MDH). Dede Hinnendael was the lead Health Regulation Division Nurse Evaluator.

Assisted living facility has has a commercial kitchen and prepares meals for about 30 residents in this building. Establishment also prepares meals for neighboring independent living living facility.

Discussed the following:
-Employee illness policy and logging requirements
-Reporting foodborne illness complaints to the health dept.
-Handwashing
-Glove-use and bare hand contact
-Proper food storage
-Thermometer calibration
-Certified Food Protection Manager renewal
-Vomit clean-up procedures
-Restrictions concerning serving a highly susceptible population
-Violations on this 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 8041231250 of 08/21/23.

Certified Food Protection Manager: Drew Swanson

Certification Number: fm63949 Expires: 10/20/23

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

Signed: _____
Drew Swanson
Culinary Director

Signed: Sarah Conboy
Sarah Conboy
Public Health Sanitarian III
651-201-3984
sarah.conboy@state.mn.us