Electronically Delivered

February 9, 2023

Licensee
Arbor Oaks Senior Living
1640 155th Lane Northwest
Andover, MN 55304

RE: Project Number(s) SL29443015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on January 6, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

The total amount you are assessed is $500.00. 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 Schoenecker, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jess.Schoenecker@state.mn.us
Phone: 651-201-3789 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29443	A. BUILDING: _____ B. WING _____	01/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR OAKS SENIOR LIVING	1640 155TH LANE NW ANDOVER, MN 55304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL29443015-0 On January 3, 2023, through January 5, 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 64 active residents; 59 receiving services under the Assisted Living with Dementia Care 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 230 SS=C	144G.18 NOTIFICATION OF CHANGES IN INFORMATION	0 230		

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0 230	Continued From page 1 A provisional licensee or licensee shall notify the commissioner in writing prior to a change in the manager or authorized agent and within 60 calendar days after any change in the information required in section 144G.12, subdivision 1, paragraph (a), clause (1), (3), (4), (17), or (18). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the commissioner in writing prior to a change in the manager or authorized agent within 60 calendar days of the change. This had a potential to affect all residents, staff and visitors of the licensee. 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 the potential to affect a large portion or all the residents). The findings include: On January 3, 2023, at 7:46 a.m., the surveyor sent the licensee the state evaluations survey notification email to the agent on file, but the email could not be delivered. On January 3, 2023, at 7:53 a.m., the surveyor called the licensee's office and was informed the agent was different and a different email given. On January 3, 2023, at 9:30 a.m., licensed assisted living director (LALD)-B indicated she had started work with licensee on October 17, 2022, which was more than 60 days to-date since	0 230		

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0 230	Continued From page 2 starting work with licensee. On January 5, 2023, at 8:30 a.m., LALD-B stated she had filed change with the department of human services (DHS) and assumed the licensee had filed a change of information with the Minnesota Department of Health (MDH). LALD-B also stated as soon the information change form was signed by company administration, LALD-B would fax it to MDH. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 230		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached	0 470		

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0 470	Continued From page 3 building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the clinical nurse supervisor developed a daily staffing schedule and posted it in a central location for residents, staff, and visitors to licensee. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On January 2, 2023, at 10:30 a.m., during the facility tour, the surveyor did not observe a posted staff schedule in any area of the facility developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning	0 470		

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0 470	Continued From page 4 of each work shift in a central location in each building. On January 2, 2023, at 10:38 a.m., registered nurse (RN)-A confirmed no staffing schedule had been posted as required and acknowledged they were not aware of the requirement to post the schedule. RN-A stated the schedule is available for staff to review in the nursing office, but not available to anyone else. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) 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: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract;	0 485		

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0 485	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all residents of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 3, 2023, at 10:20 a.m., the surveyor observed the menu plan posted on the bulletin board was for one week running from Monday, January 2, 2023, through Sunday, January 8, 2023. The observed menu was not prepared at least one week in advance. On January 5, 2023, at 9:22 a.m., regional director (RD)-G acknowledged the menu was not prepared at least one week in advance. RD-G also stated the menu will be prepared two weeks in advance and handed to all residents. The licensee's undated Meal Plan Addendum policy indicated menus for all meals will be available to residents prepared one week in advance and posted. No further information provided.	0 485		

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0 485	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	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 had the potential to affect the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	0 510		

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0 510	Continued From page 7 The findings include: On January 4, 2023, at 7:53 a.m., during breakfast in the memory care unit common area, the surveyor observed unlicensed personnel (ULP)-E performed no hand hygiene prior to serving beverages and meals to five residents. On January 4, 2023, at approximately 7:59 a.m., the surveyor observed ULP-E assist a resident seated in their wheelchair to the table, then don gloves without completing hand hygiene, and prepare beverages for five residents in the common dining room. On January 4, 2023, at 8:01 a.m., ULP-E assisted R10 with getting off the toilet. ULP-E then placed an incontinent pull up on R10, dressed lower body, and dressed upper body without removing soiled gloves or performing hand hygiene. ULP-E then completed oral cares on R10 and groomed R10's hair without removing soiled gloves or performing hand hygiene. On January 4, 2023, at 8:15 a.m., the surveyor observed ULP-E in the memory care hallway don gloves. ULP-E stated was going to assist a resident with morning medication. ULP-E entered R1's room and completed medication administration for R1. ULP-Ethen took off the gloves and donned a clean pair of gloves before completing hand hygiene. On January 4th, 2023, at 9:00 a.m., surveyor observed breakfast for all the memory care residents. ULP-E served residents food with gloves, continued to wear gloves without changing or completing hand hygiene. The surveyor observed ULP-E touch a resident's back, then pick up a new breakfast plate from	0 510		

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0 510	Continued From page 8 kitchen and place it in front of a resident to eat. ULP-E cleared plates with dirty gloves and served more residents coming to the dining room for breakfast. On January 4, 2023, at 9:46 a.m., the surveyor observed ULP-E and ULP-I in the memory care dining room assist residents to join activities with their gloves donned. On January 4, 2023, at approximately 10:38 a.m., registered nurse (RN)-A stated staff were expected to wash their hands before and after medication pass, delegated tasks, toileting, meals, in between residents, and when hands were soiled. RN-A stated gloves are only donned in the resident rooms when assisting residents with cares and all ULPs are trained to wash their hands before and after gloving. RN-A also stated gloves will donned outside of resident room only when cleaning after meals and/or accidents. The Centers for Disease Control and Prevention (CDC) Hand Hygiene in Health Care Settings Healthcare Providers dated January 8, 2021, directed health care workers to wash their hands immediately before touching a patient [resident], after touching a patient or patient's immediate environment, after glove removal, and when hands were visibly soiled. The licensee's Infection Prevention and Control Program dated April 2020, was to establish and maintain a program designed to provide a safe and sanitary environment for all resident/tenants/patients, their families, volunteers, visitors and staff. The program is to have oversight by an infection preventionist or licensed nurse who is responsible to review policies/procedures and guidelines, establish a	0 510		

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0 510	Continued From page 9 surveillance system and review surveillance information to make recommendations based on the data. The licensee's Gloving policy dated April 2020, indicated gloves provided a protective barrier and prevented contamination of the hands when in contact with blood, body fluids, and non-intact skin. The policy indicated staff should wash hands after use of gloves. The licensee's Hand Hygiene policy dated July 2021, indicated proper hand washing techniques should be used to prevent the spread of infection. The policy also indicated hand washing should be performed by all employees as necessary between tasks and procedures, and after bathroom use to prevent cross contamination. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630		

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0 630	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed or included a review/assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse 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 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: R4 admitted to licensee on August 2, 2022. R4's record lacked an individual abuse prevention plan (IAPP). On January 4, 2023, at 9:37 a.m., licensed assisted living director (LALD)-B stated R3 is completely independent and does not have an IAPP. On January 4, 2023, at 10:25 a.m., registered nurse (RN)-A stated they do not complete IAPPs for any of the independent residents. The licensee's Individual Abuse Prevention Plan	0 630		

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0 630	Continued From page 11 policy dated October 2015 and revised March 2021, and July, 2021, indicated each facility shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 640		

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	29443	A. BUILDING: _____ B. WING _____	01/06/2023

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0 640	Continued From page 12 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: On January 2, 2023, at 10:45 a.m., the surveyor observed the common area of the facility which lacked a posting of the 911 emergency number. On January 3, 2023, at 2:07 p.m., licensed assisted living director (LALD)-B confirmed the 911 emergency number information was not posted in the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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	0 680		

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0 680	Continued From page 13 (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 by: 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 residents receiving services under the assisted living license. 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 the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: 1. Emergency plan does not include minimum food, water, and pharmaceutical supplies. 2. Emergency plan did not completely address	0 680		

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0 680	Continued From page 14 development of arrangements with other facilities/providers to receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents. On January 4, 2023, at 1:43 p.m., licensed assisted living director (LALD)-B acknowledged the EPP lacked the required content. LALD-B stated there was not a signed contract or agreement with the outside community to accept residents in case of an emergency. They had identified another licensee as the accepting facility, but nothing had been signed between the licensees. LALD-B also stated there was not a written plan including the minimum supplies needed and who would be housing those. LALD-B stated the licensee was working with sister facilities to update their EPPs to include all required content. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated July 20, 2021, indicated the licensee would have suggested supplies including: - food: three to ten days or more of food and water; - one gallon of water per person per day; - resident medications: three-day supply minimum; - personal protective equipment: gloves, gowns, and masks; - hygiene supplies; - assisting devices; - computer with batteries; - portable communication radios with batteries; - flashlights with batteries; - weather radio with batteries; and - construction supplies to repair minor damages.	0 680		

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0 680	Continued From page 15 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the residents' personal health and medical information was kept private. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 3, at 11:55 a.m., during the facility tour, the surveyor observed the service schedule list left laying accessible in the open, on a table in	0 700		

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0 700	Continued From page 16 the great room of the memory care unit. The great room is an open public area. The service schedule listed names and rooms of all residents, along with diagnosis, room numbers, and other protected data and personal health information. On January 3, 2023, at 12:05 p.m., registered nurse (RN)-A stated personal health and medical information should be kept private and not left out and unattended. The licensee's Client [resident] Record policy dated July 2021, indicated to ensure compliance, client [resident] records would be stored in a secure designated area. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
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	0 810		

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0 810	Continued From page 17 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for 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 interview and record review, the licensee failed to provide the required training to residents and employees for fire safety and evacuation, and failed to conduct required employee evacuation drills. This had the potential to affect all current residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include:	0 810		

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0 810	Continued From page 18 During interview on January 03, 2023, at 1:30 p.m., the Regional Director of Maintenance (DM)-J stated they had not completed the required training and evacuation drills. Review of the Fire Plan and Evacuation Plan showed the following: 1. No record of required employee evacuation drills. 2. No schedule or records on the training of employees on fire safety and evacuation; on proper actions to take in the event of a fire or emergency for the safety of residents including movement, evacuation, or relocation. 3. No schedule or records on the training of residents who are capable of assisting in their evacuation; on proper actions to take in the event of a fire or emergency for their safety including movement, evacuation, or relocation. 4. Posted evacuation plans showed the location of rooms, but did not include apartment numbers. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	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.	01060		

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01060	Continued From page 19 (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 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 required content for an emergency relocation and	01060		

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01060	Continued From page 20 failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of three residents (R3). 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: R3 started receiving services on March 16, 2021, under the comprehensive license and started receiving assisted living services August 1, 2021. R3's service plan dated August 8, 2022, indicated R3 received assistance with medication administration, blood glucose monitoring, and activities of daily living (ADLs). R3's record indicated R3 went to the emergency room on October 15, 2022, and was admitted to the hospital. R3's record lacked a written notice including: - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date 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 - a statement that, if the facility refuses to provide housing or services after a relocation, the	01060		

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01060	Continued From page 21 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. R3's record lacked notification to the Office of Ombudsman for Long-Term Care that the resident had been relocated and had not returned to the facility within four days. On January 4, 2023, at 1:30 p.m., registered nurse (RN)-A stated they were not aware of this requirement and have not been sending the required written notice for any residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff providing services completed orientation to assisted living facility licensing requirements and regulations before	01460		

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01460	Continued From page 22 providing services for one of two employees (unlicensed personnel (ULP)-F). 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). The findings include: ULP-F started employment with the licensee on February 4, 2022. ULP-F's employee record lacked documentation that orientation to assisted living requirements was provided to include: - Overview of assisted living statutes; - Review of provider's policies and procedures; - Handling of emergencies and use of emergency services; - Reporting maltreatment of vulnerable adults or minors; - Assisted living bill of rights; - Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; - Review of types of assisted living services the employee will provide and provider's scope of	01460		

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01460	Continued From page 23 license; and - Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On January 5, 2023, at 10:03 a.m., registered nurse (RN)-A and licensed assisted living director (LALD)-B confirmed there was no orientation records available for ULP-F. The licensee's undated Onboarding Experience document indicated, "Agency will provide orientation and training to all staff at the time of hire and as needed to meet state guidelines and quality standards. Orientation will be provided to staff before they provide Assisted Living services to clients. Orientation will be completed once for each staff person and will not be transferable to another Assisted Living provider." The document did not reflect the current Assisted Living Orientation requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01460		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to	01540		

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01540	Continued From page 24 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; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct-care staff completed the required amount of dementia care training in the required time frame for one of two employees (unlicensed personnel (ULP)-C). 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). The findings include: The licensee held a current Assisted Living Facility with Dementia Care (ALFDC) license effective August 1, 2022, through October 31, 2023. ULP-C started employment with licensee on November 2, 2015, under the comprehensive license, and began providing services on August 1, 2021, under the assisted living license. ULP-C's training records indicated ULP-C had	01540		

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01540	Continued From page 25 completed the following dementia related online courses: -philosophy and guiding concepts to caring for residents with Alzheimer's disease - 1 hour -tips for communicating with individuals who have Alzheimer's disease - 1 hour -the foundation of memory care - .75 hours - building relationships and community - 1 hour - redefining behaviors and environmental influence - 1 hour -meaningful life and engagement - .75 hours -understanding Alzheimer's disease/dementia - 1 hour ULP-C's employee record lacked at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. On January 5, 2023, at 9:30 a.m., regional director (RD)-G stated staff complete eight hours of dementia training prior to starting on the floor, they also complete hours throughout the year through Relias (online training modules). On January 5, 2023, at 10:25 a.m., licensed assisted living director (LALD)-B stated she does not have documentation of eight hours of dementia care training for ULP-C. The licensee's undated document titled Minnesota Assisted Living (144G) indicated ULPs will have eight hours of dementia training within 80 work hours after the first day of hire. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR OAKS SENIOR LIVING	1640 155TH LANE NW ANDOVER, MN 55304

(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
01610	Continued From page 26	01610		
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a 14-day comprehensive assessment to cover all parts of the uniform assessment tool for two of two residents (R8, R10). 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).	01610		

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01610	Continued From page 27 The findings include: R8 started receiving services from the licensee on November 28, 2022. R8's record included a preadmission assessment completed on November 8, 2022. R8's assessment included a level of care assessment, BIMS and medication assessment. R10 started receiving services from the licensee on August 4, 2022. R10's record included a preadmission assessment completed on August 4, 2022. R10's assessment included a level of care assessment, BIMS and medication assessment. R8 and R10's assessments lacked required parts of the uniform assessment tool to include: - The resident's personal lifestyle preferences, including: sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life; spiritual and cultural preferences; and advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order; - Instrumental activities of daily living, including: housework and laundry; and transportation; - physical health status: a review of relevant health history and current health conditions, including medical and nursing diagnoses; allergies and sensitivities related to medication, seasonality, environment, and food and if any of	01610		

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01610	Continued From page 28	01610		

the allergies or sensitivities are life threatening, infectious conditions; a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility, a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months, weight; and initial vital signs if indicated by health conditions or medications;
- emotional and mental health conditions;
- communication and sensory capabilities;
- pain;
- skin conditions;
- nutritional and hydration status and preferences;
- list of treatments, including type, frequency, and level of assistance needed;
- nursing needs, including potential to receive nursing-delegated services;
- risk indicators; and
- who has decision-making authority for the resident.

On January 5,2022 at 10:15 a.m., regional director (RD)-G, stated the licensee's preassessment covers all the required uniform assessment tool sections. RD-G also stated the same assessment tool was used for the licensee's residents.

The licensee's Comprehensive Assessment Schedule guideline dated August 2022, indicated the RN will complete an individualized preassessment and complete client monitoring and reassessment within 14 days.

No further information was provided.

TIME PERIOD FOR CORRECTION:

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	29443	A. BUILDING: _____ B. WING _____	01/06/2023

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ARBOR OAKS SENIOR LIVING	1640 155TH LANE NW ANDOVER, MN 55304

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01610	Continued From page 29 Twenty-One (21) days	01610		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (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. (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. (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessments not to exceed 90 calendar days from the last date of the assessment for one of five residents (R2).	01620		

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01620	Continued From page 30 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). The findings include: R2's record included a comprehensive assessment dated May 10, 2022, and a 90-day nursing assessment dated August 20, 2022, which exceeded 90 calendar days from the last date of the last assessment by 12 days. On January 4, 2022, at 12:05 a.m., RN-A stated R2's ongoing nursing assessments exceeded 90 calendar days from the last date of the previous assessment. RN-A stated not all the assessments were being done timely. The licensee's Comprehensive Assessment Schedule tool dated August 2022, indicated ongoing client monitoring and reassessment must be conducted at least every 90 days from the last date of assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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	01760		

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ARBOR OAKS SENIOR LIVING	1640 155TH LANE NW ANDOVER, MN 55304

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01760	Continued From page 31	01760		

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 prescriber orders were transcribed accurately for one of one resident (R3).

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 January 4, 2023, at 11:00 a.m., the surveyor observed licensed practical nurse (LPN)-H administer R3's medications.

R3's diagnoses included hypertension, diabetes, and depression.

R3's prescriber orders dated December 12, 2022,

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01760	Continued From page 32	01760		

included the following scheduled medications:
- Baza Protect topical cream - apply topically to affected area twice daily (BID)
- metoprolol succinate ER 25 mg (milligram) - 1 tablet (tab) two times a day
- amlodipine 10 mg - 1 tab daily
- venlafaxine 75 mg - 1 tab two times a day
- atorvastatin 20 mg - 1 tab daily
- glucosamine/chondroitin 250/200 mg - 2 capsules (cap) daily
- lisinopril 40 mg - 1 ½ tabs (60 mg) daily
- gabapentin 100 mg - 1 cap daily
- oxybutynin chloride 5 mg - 1 tab daily
- glimepiride 4 mg - 2 tab (8 mg) daily
- Breo Ellipta 200 micrograms (mcg)- 25 mcg - inhale one puff daily
- aripiprazole 2 mg - 1 tab daily
- Lantus Solostar 100 unit/ milliliter (mL) - Inject 27 units subcutaneous daily in the evening (p.m.)
- Tradjenta 5 mg - 1 tab daily
- cholecalciferol 50 mcg - 1 tab daily
- Humalog 100 unit/mL - inject 12 units subcutaneous three times daily
- Lantus Solostar 100 unit/mL - inject 39 units subcutaneous daily

R3's medication administration record (MAR) for December 2022 showed the following:
- Baza Protect topical cream - apply topically to affected area BID
- metoprolol succinate ER 25 mg - 1/2 tab two times a day
- amlodipine 10 mg - 1 tab daily
- venlafaxine 75 mg - 1 tab two times a day
- atorvastatin 20 mg - 1 tab daily
- glucosamine/chondroitin 250/200 mg - 2 cap daily
- lisinopril 40 mg - 1 tab daily
- gabapentin 100 mg - 1 cap daily

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01760	Continued From page 33 - oxybutynin chloride 5 mg - 1 tab daily - glimepiride 4 mg - 2 tab (8 mg) daily - Breo Ellipta 200 mcg - 25 mcg - inhale one puff daily - aripiprazole 2 mg - 1 tab daily - Lantus Solostar 100 unit/ mL - Inject 27 units subcutaneous daily in the p.m. - Tradjenta 5 mg - 1 tab daily - cholecalciferol 50 mcg - 1 tab daily - Humalog 100 unit/mL - inject 12 units subcutaneous three times daily - Lantus Solostar 100 unit/mL - inject 39 units subcutaneous daily R3's MAR lacked the correct dosage for lisinopril and metoprolol succinate ER per R3's most current provider's orders. On January 4, 2023, at 12:37 p.m. registered nurse (RN)-A stated R3's MAR was incorrect when checked against the provider orders. RN-A stated she will reach out to the provider for clarification and follow their policy for the medication error. The licensee's Medication and Treatments policy dated August 2014 with revision date of March 2021, indicated the medication and treatment record must be kept current and updated with any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

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02040	Continued From page 34 An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct a hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 residents). The findings include: During interview on January 03, 2023, at 1:00 p.m., the Regional Director of Maintenance (DM)-J stated they had not developed specific mitigation strategies for any identified hazards. Review of the Facility Wide Resource Assessment, dated 07-28-2021 showed the hazard vulnerability assessment as being	02040		

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02040	Continued From page 35 included in Appendix A, but the document provided to the surveyor did not include the hazard vulnerability assessment. Items identified within Appendix A were Facility Assessment Details for "Clinical Profile", "Staffing Profile", "Building & Physical Environment", "Equipment & Systems", and "Contracts, Agreements & Memorandums". Documents in Appendix A identified building elements, the count, and the condition of the elements, but did not include any potential hazards or mitigation strategies for issues found on and around the property. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *01/04/23*
Time: 10:19:38
Report: 1024231001

Food and Beverage Establishment Inspection Report

Location:
Arbor Oaks Senior Living
1640 155th Lane Nw
Andover, MN55304
Anoka County, 02

Establishment Info:
ID #: 0038199
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7632052248
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.

No NEW orders were issued during this inspection.

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

NO INSPECTION CONDUCTED DUE TO ARBOR OAKS KITCHEN STAFF IS EMPLOYED BY 3RD PARTY VENDOR, CURA. BISTRO IS STOCKED BY 3RD PARTY VENDOR, CURA. LICENSING INFORMATION WILL BE PASSED ONTO DELEGATED AGENCY.

DISCUSSED THE ABOVE WITH NURSING EVALUATOR IN CHARGE, BENARD NYANGENA AND KATHY BESST, MARKETING DIRECTOR.

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 1024231001 of 01/04/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
KATHY BESST
MARKETING DIRECTOR

Signed:_____
Sheng Yang
Public Health Sanitarian I
Freeman Building
651-201-3985
sheng.yang@state.mn.us