Electronically Delivered

August 10, 2023

Licensee
Boden Senior Living Apple Valley
5399 155th Street West
Apple Valley, MN 55124

RE: Project Number(s) SL38743015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on August 2, 2023, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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
Per 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 residents/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 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/or 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: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38743	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING APPLE VALLEY	5399 155TH STREET WEST APPLE VALLEY, MN 55124

(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: SL38743015-0 On August 1, 2023, through August 2, 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 33 residents receiving services under the Provisional 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including	0 800		

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0 800	Continued From page 1 walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. 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 potential to affect a large portion or all of the residents). Findings include: On a facility tour on August 2, 2023, at approximately 11:30 a.m. with director of maintenance (DM)-F and regional environmental services lead (ESL)-E it was observed the fire sprinkler head was covered with a paint masking cover in the mechanical room located in storage area across the corridor from the wellness center. Fire sprinkler heads are required to be maintained in operable condition. It was also observed that an electrical light fixture was missing the cover in resident room 146.	0 800		

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0 800	Continued From page 2 Electrical light fixtures are required to be maintained as designed and installed according to manufactures listed instructions. These deficient conditions were visually verified by DM-F and ESL-E accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in 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.	0 810		

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0 810	Continued From page 3 (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 record review and interview, the licensee failed to maintain the facility's fire safety and evacuation plan with required elements. 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 potential to affect a large portion or all of the residents). Findings include: A record review of available documentation and interview were conducted on August 2, 2023, at approximately 10:30 a.m. of documents provided by director of maintenance (DM)-F and regional environmental services lead (ESL)-E on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. A record review of the available documentation indicated that the fire safety and evacuation map posted in egress corridors did not list room locations and room numbers. The fire safety and	0 810		

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0 810	Continued From page 4 evacuation plan map is required to include locations and number of resident rooms. A record review of available documentation indicated the door to the secured exterior area from the dementia care unit marked as an emergency exit. Doors indicated as an emergency exit on the plan are required to be marked as an emergency exit and lead from the interior of the building to the public way. During a tour of the facility, it was observed this door was not marked as a required emergency exit. Record review of the available documentation indicated the licensee did not have unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency available with the fire safety and evacuation plan. Individual unique and unusual needs of each resident for evacuation during a fire or similar emergency is required to be available within the fire safety and evacuation plan. Record review of the available documentation indicated that employees received training related to the fire safety and evacuation plan for the facility but not in the required sequence. Employee training is required to be completed and documented upon initial hire and twice per year thereafter on the facility fire safety and evacuation plan. Employee training is required to be documented separately from drills. Record review of the available documentation indicated that evacuation drills had been conducted but not in the required sequence of at least once every other month and twice per year per shift. Fire and evacuation drills are required to be documented separately from employee training.	0 810		

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0 810	Continued From page 5 All deficiencies were verified by DM-F and ESL-E during the interview at approximately 11:00 a.m. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.	0 950		

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0 950	Continued From page 6 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of representative statutory language for three of three residents (R2, R3, and R4). This practice resulted in a level one violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2's record included a copy of an untitled form that discussed designated representative rights dated November 25, 2022. R3's record included a copy of an untitled form that discussed designated representative rights dated January 6, 2023. R4's record included a copy of an untitled form that discussed designated representative rights dated January 14, 2023. The untitled form in R2, R3, and R4's records lacked the required verbatim language required at the time of execution of the contract. On August 2, 2023, at 1:00 p.m., licensed assisted living director (LALD)-C stated the required verbatim notice was not included in the residents' assisted living contracts; although	0 950		

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0 950	Continued From page 7 residents did have the ability to designate a representative in the assisted living contract, the verbatim language notice was not provided to the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living 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 implement a completed assessment to address the cognitive and physical needs for one of three residents (R4).	01610		

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01610	Continued From page 8 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: R4 was admitted on January 19, 2023. R4's New Nursing Assessment dated May 16, 2023, indicated under section Individual Abuse Prevention Plan, R4 was not orientated to person, place, and time due to impaired memory and/or cognition and was not able to maintain a clean and safe environment. R4's Service Agreement with effective date of August 2, 2023, indicated R4 received the services of laundry, blood glucose monitoring, medication assist, and reminders under the licensee's Memory Care Level 2 package. On August 2, 2023, at 7:15 a.m. during observation of R4's services bring provided in R4's room, a sharp metal kitchen steak knife and a sharp metal red handled scissors were noted in an unsecured drawer in R2's apartment. On August 2, 2023, at 10:45 a.m., licensed assisted living director (LALD)-C and clinical nurse supervisor (CNS)-D stated the knife and scissors noted in R4's apartment should not be in R4's room and would need to be removed immediately. CNS-D stated no knives or scissors	01610		

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01610	Continued From page 9 should be accessible by any residents who resided in the licensee's secured unit. LALD-C stated licensee completed searches for items that should not be in residents' rooms, but these two items were missed and would be removed. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) 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.	01620		

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01620	Continued From page 10 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 a 14-day reassessment for one of three residents (R2). 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: R2 was admitted on November 28, 2022. R2's initial Nursing Assessment was dated November 28, 2022. R2's next nursing assessment was documented as the 90-day assessment and was dated February 26, 2022. R2's record lacked a 14-day assessment. On August 2, 2023, at 11:25 a.m., clinical nurse supervisor (CNS)-D stated R2's 14-day reassessment was not completed. CNS-D stated the licensee was initially unaware a 14-day reassessment was required to be completed after initiation of services. CNS-D said once the licensee learned a 14-day reassessment needed to be completed, the licensee completed 14-day reassessments going forward. The licensee's Comprehensive Assessment Schedule policy dated August 2022, indicated	01620		

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01620	Continued From page 11 monitoring and reassessment would be completed within 14 days after initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan	01640		

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01640	Continued From page 12 included a signature or other authentication by the licensee and resident or resident's representative to document agreement of services to be provided for one of three residents (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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted on January 19, 2023. R4's Service Agreement dated January 19, 2023, was identified by licensed assisted living director (LALD)-C as R4's most recent authenticated service plan. R4's Service Agreement dated August 2, 2023, identified by LALD-C as R4's currently enacted service plan, included 14 revised or added services with an "Effective Date," after R4's authenticated service plan from January 19, 2023. Additionally, R4's current service plan included an increase in price for the services provided. On August 2, 2023, at 1:00 p.m., LALD-C stated R4's service plan from January 19, 2023, did not include the accurate pricing for the services at that time. Although the pricing for the services on the authenticated service plan in January was indicated as being lower that the service plan on	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38743	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BODEN SENIOR LIVING APPLE VALLEY	5399 155TH STREET WEST APPLE VALLEY, MN 55124

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01640	Continued From page 13 August 2, 2023, the price on the January service plan did not reflect the pricing for rent. LALD-C stated the pricing on the August 2, 2023, service plan was lower than R4 was originally playing, and the services had changed resulting in the lower price. LALD-C stated the service plan should have been authenticated when the change in price and services occurred. The licensee's Service Plan policy dated April 2023, indicated the service plan and any revisions would be authenticated by the licensee and the resident or resident's designated representative. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of three residents (R4) reviewed with medication management services. 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	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38743	A. BUILDING: _____ B. WING _____	08/02/2023

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BODEN SENIOR LIVING APPLE VALLEY	5399 155TH STREET WEST APPLE VALLEY, MN 55124

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01880	Continued From page 14 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted on January 19, 2023. R4's Service Agreement with effective date of August 2, 2023, indicated R4 received the service of, "Medication Assist/Admin," which started on January 18, 2023. R4's NEW Nursing Assessment dated May 17, 2023, read under the Medication and Treatment Evaluation and Management Plan section, "Resident's meds are managed by [licensee] nurse. They are delivered in blister cards every 28 day cycle by [business name] pharmacy and reviewed for accuracy by [licensee] RN/LPN. Medications are then supplied by trained HHA or Nurse to the resident's apartment and locked in cabinet in the kitchen. Any refrigerated meds are kept in locked box in the refrigerator and narcotics if any double locked in the kitchen cabinet also." On August 2, 2023, at 7:15 a.m. during observation of R2's medication administration, the surveyor noted a green plastic lockbox in R2's refrigerator with an unsecured lock. The lock was hooked through a security hole between the top and bottom sections of the box, but the lock was unclasped. Unlicensed personnel (ULP)-A accessed the lockbox to retrieve a medication for R4. ULP-A then locked the lock and secured the lockbox. ULP-A stated the lockbox should always be locked to prevent R4 from accessing any	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38743	A. BUILDING: _____ B. WING _____	08/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01880	Continued From page 15 medications stored within. On August 2, 2023, at 11:00 a.m., licensed assisted living director (LALD)-C and clinical nurse supervisor (CNS)-D stated R4's medications should have been secured in the lockbox and locked. CNS-D stated the lockbox contained R4's overflow insulin medication and was required to be secured for the safety of R4 based on the nurse's assessment. The licensee's Medication and Treatment policy dated March 2021, indicated medications would be secured according to the nurse's assessment and according to manufacturer's recommendation. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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

Type: Partial-NOO
Date: *08/01/23*
Time: 15:45:50
Report: 1004231081

Food and Beverage Establishment Inspection Report

Location:
Boden Senior Living Apple Vall
5399 155th Street W
Apple Valley, MN55124
Dakota County, 19

Establishment Info:
ID #: 0041347
Risk: High
Announced Inspection: No

License Categories:
HOSP, FBLB, FBC3

Expires on: 12/31/23

Operator:
Cura Hospitality LLC

Phone #:
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

FOOD SERVICE AND LICENSING VERIFICATION WAS CONDUCTED BY MOLLY DOUGHERTY (FPLS) IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION (HRD) SURVEY CONDUCTED BY BRANDON MUELLER.

FOOD SERVICE AT THIS ESTABLISHMENT IS PROVIDED THROUGH A 3RD PARTY SERVICE, CURA. NO FOOD SERVICES ARE PROVIDED BY BODEN STAFF.

ESTABLISHMENT HAS BEEN LICENSED BY THE FOOD, POOLS, AND LODGING SERVICES (FPLS) SECTION, AND FUTURE FOOD SERVICE INSPECTIONS WILL FALL UNDER FPLS SCHEDULE. FULL INSPECTION HAS ALREADY BEEN CONDUCTED ON 7/11/23.

NO INSPECTION WAS CONDUCTED DURING FOOD SERVICE VERIFICATION.

Type: Partial-NOO
Date: *08/01/23*
Time: 15:45:50
Report: 1004231081
Boden Senior Living Apple Vall

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1004231081 of 08/01/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed: Molly Dougherty
Molly Dougherty
Public Health Sanitarian
Metro District Office
651-201-3978
molly.dougherty@state.mn.us