



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

June 27, 2024

Licensee

Evergreen Assisted Living Homes Inc.

5517 Highland Road

Minnetonka, MN 55345

RE: Project Number(s) SL40487015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. 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](mailto:Health.assistedliving@state.mn.us).

The Minnesota Department of Health completed an initial survey on May 29, 2024, 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.

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

#### **STATE CORRECTION ORDERS**

The enclosed State Form documents the state correction orders. 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 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.

To submit a reconsideration request, please visit:

**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at [susan.winkelmann@state.mn.us](mailto:susan.winkelmann@state.mn.us) or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor  
State Evaluation Team  
Email: [Jess.Schoenecker@state.mn.us](mailto:Jess.Schoenecker@state.mn.us)  
Telephone: 651-201-3789 Fax: 1-866-890-9290

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Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>40487 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |  | (X3) DATE SURVEY COMPLETED<br><br>05/29/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>EVERGREEN ASSISTED LIVING HOMES INC |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>5517 HIGHLAND ROAD<br>MINNETONKA, MN 55345                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |  |                                              |
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| 0 000                                                                   | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING<br/>CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, these correction orders are<br/>issued pursuant to a survey.</p> <p>Determination of whether violations are corrected<br/>requires compliance with all requirements<br/>provided at the Statute number indicated below.<br/>When Minnesota Statute contains several items,<br/>failure to comply with any of the items will be<br/>considered lack of compliance.</p> <p>INITIAL COMMENTS:</p> <p>SL40487015</p> <p>On May 28, 2024, through May 29, 2024, the<br/>Minnesota Department of Health conducted an<br/>intial survey at the above provider, and the<br/>following correction orders are issued. At the time<br/>of the survey, there were 4 residents receiving<br/>services under the provider's Provisional Assisted<br/>Living license.</p> | 0 000                                                           | <p>Minnesota Department of Health is<br/>documenting the State Correction Orders<br/>using federal software. Tag numbers have<br/>been assigned to Minnesota State<br/>Statutes for Assisted Living Facilities. The<br/>assigned tag number appears in the<br/>far-left column entitled "ID Prefix Tag." The<br/>state Statute number and the<br/>corresponding text of the state Statute out<br/>of compliance is listed in the "Summary<br/>Statement of Deficiencies" column. This<br/>column also includes the findings which<br/>are in violation of the state requirement<br/>after the statement, "This Minnesota<br/>requirement is not met as evidenced by."<br/>Following the evaluators ' findings is the<br/>Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF<br/>THE FOURTH COLUMN WHICH<br/>STATES,"PROVIDER'S PLAN OF<br/>CORRECTION." THIS APPLIES TO<br/>FEDERAL DEFICIENCIES ONLY. THIS<br/>WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO<br/>SUBMIT A PLAN OF CORRECTION FOR<br/>VIOLATIONS OF MINNESOTA STATE<br/>STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS<br/>USED FOR TRACKING PURPOSES AND<br/>REFLECTS THE SCOPE AND LEVEL</p> |  |                                              |

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Minnesota Department of Health

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| 0 480<br>SS=F                                                                  | <b>144G.41 Subd 1 (13) (i) (B) Minimum requirements</b><br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 29, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480                                                                                       |                                                                                                                          |  |                                                        |



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| 0 550<br>SS=F                                                                  | <p><b>144G.41 Subd. 7 Resident grievances; reporting maltreatment</b></p> <p>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all the licensee's current residents, staff, and visitors.</p> <p>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).</p> <p>The findings include:</p> | 0 550                                                                  |                                                                                                                          |  |                                                     |



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| 0 550                                                                          | <p>Continued From page 3</p> <p>On May 28, 2024, at approximately 10:30 a.m., during a facility-wide tour, the surveyor did not observe a posting of the required grievance procedure content in a conspicuous place.</p> <p>On May 28, 2024, at approximately 12:05 p.m., registered nurse (RN)-A confirmed the required grievance procedure content had not been posted but explained to surveyor they did provide the information on the licensee's grievance policy to each resident when they were admitted. RN-A also stated the form to complete a grievance was available in a paper holder on the wall near the front entrance of the building.</p> <p>The licensee's Complaint Policy and Procedure dated June 25, 2021, did not indicate the information would be posted in an area accessible to residents, visitors, and employees.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 0 550                                                                  |                                                                                                                          |  |                                                     |
| 0 660<br>SS=F                                                                  | <p>144G.42 Subd. 9 Tuberculosis prevention and control</p> <p>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled</p>                                                                                                                                                                                                                                                                                                                                                              | 0 660                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

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| 0 660                                                                          | <p>Continued From page 4</p> <p>volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk assessment.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>During the entrance conference on May 28, 2024, at approximately 10:40 a.m. with registered nurse (RN-A), a request was made to review the facility TB risk assessment. RN-A stated the licensee had not completed a facility TB risk assessment since sometime in 2018, but they did not have a recent TB risk assessment completed.</p> <p>The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a</p> | 0 660                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

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| 0 660                                                                          | Continued From page 5<br><br>facility TB risk assessment.<br><br>The licensee's TB Prevention and Control policy, dated July 11, 2016, noted the administrator would be responsible for conducting the risk assessment and the TB Prevention Plan and Risk Assessment would be reviewed every other year.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 0 660                                                                  |                                                                                                                          |  |                                                     |
| 0 680<br>SS=F                                                                  | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. | 0 680                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>40487</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>05/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EVERGREEN ASSISTED LIVING HOMES INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5517 HIGHLAND ROAD<br/>MINNETONKA, MN 55345</b>                              |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 680                                                                          | <p>Continued From page 6</p> <p>(c) The facility must meet any additional requirements adopted in rule.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to post an emergency preparedness plan prominently. This had the potential to impact all residents, staff, and visitors to the licensee's facility.</p> <p>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).</p> <p>The findings include:</p> <p>On May 28, 2024, at approximately 11:25 a.m., during a tour of the facility, the surveyor did not observe any signage or information regarding the licensee's emergency disaster or preparedness plan posted in a prominent location.</p> <p>On May 28, 2024, at approximately 12:10 p.m., the surveyor requested the licensee's emergency disaster or preparedness plan. Registered nurse (RN)-A provided a binder consisting of the licensee's policies for the surveyor to review.</p> <p>During an interview on May 29, 2024, at approximately 2:15 p.m., RN-A stated she was not aware the licensee had not posted the emergency preparedness information. RN-A stated she was aware the licensee had posted the emergency exit diagram but had thought</p> | 0 680                                                                  |                                                                                                                          |  |                                                     |



Minnesota Department of Health

|                                                                                |                                                                                                                                                                                 |                                                                           |                                                                                                                          |  |                                                        |
|--------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>40487</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>05/29/2024</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>EVERGREEN ASSISTED LIVING HOMES INC</b> |                                                                                                                                                                                 |                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>5517 HIGHLAND ROAD<br/>MINNETONKA, MN 55345</b>                              |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                       | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                    | ID<br>PREFIX<br>TAG                                                       | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                                          | Continued From page 7<br><br>emergency preparedness plan was also posted.<br><br>No additional information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days | 0 680                                                                     |                                                                                                                          |  |                                                        |



Type: Full  
Date: 05/29/24  
Time: 13:00:00  
Report: 8041241082

## Food and Beverage Establishment Inspection Report

Page 1

**Location:**

Evergreen Assisted Living Home  
5517 Highland Road  
Minnetonka, MN55345  
Hennepin County, 27

**Establishment Info:**

ID #: 0042675  
Risk:  
Announced Inspection: No

**License Categories:**

Expires on: 12/31/24

**Operator:**

Phone #: 6512800210  
ID #:

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

The following orders were issued during this inspection.

### 3-300B Protection from Contamination: cross-contamination, eggs

#### 3-302.11A(1)

**\*\* Priority 1 \*\***

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

PACKAGE OF RAW PORK AND SHELL EGGS STORED ABOUT READY-TO-EAT FOOD IN THE REFRIGERATOR. ITEMS MOVED TO LOWER SHELF DURING INSPECTION.

*Comply By: 05/29/24*

### 2-100 Supervision

#### 2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

ESTABLISHMENT DOES NOT CURRENTLY HAVE A CERTIFIED FOOD PROTECTION MANAGER. ASHLEY PITTS TOOK SERVE SAFE MORE THAN 6 MONTHS AGO. FACT SHEET AND APPLICATION SENT WITH REPORT.

*Comply By: 05/29/24*

### Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 41 Degrees Fahrenheit - Location: kitchenaid refrigerator: ham

Violation Issued: No

Process/Item: Cold Holding

Temperature: 41 Degrees Fahrenheit - Location: kitchenaid refrigerator: yogurt

Violation Issued: No



Type: Full  
Date: 05/29/24  
Time: 13:00:00  
Report: 8041241082  
Evergreen Assisted Living Home

# Food and Beverage Establishment Inspection Report

Page 2

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

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Inspection was completed with Ashley Pitts. Elyse Jones was the lead Health Regulation Division Nurse Evaluator. Facility had four residents on site at time of inspection.

This establishment has a residential kitchen. Food must be prepared for same day service only. The kitchen has wood cabinets with a hollow base, a solid surface countertop and vinyl flooring. All found to be in good condition.

A two basin sink is located in the kitchen with one basin designated for handwashing. Establishment has a Kitchenaid dishwasher that has a sani rinse/high temp cycle and achieved a temp at least 160 F for sanitizing dishes.

Discussed the following:

- Employee illness policy and logging requirements
- Handwashing
- Glove-use and bare hand contact
- Thawing
- Food storage and preventing cross contamination
- Date marking
- Restrictions concerning serving a highly susceptible population
- Vomit clean up process
- Proper cold holding

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

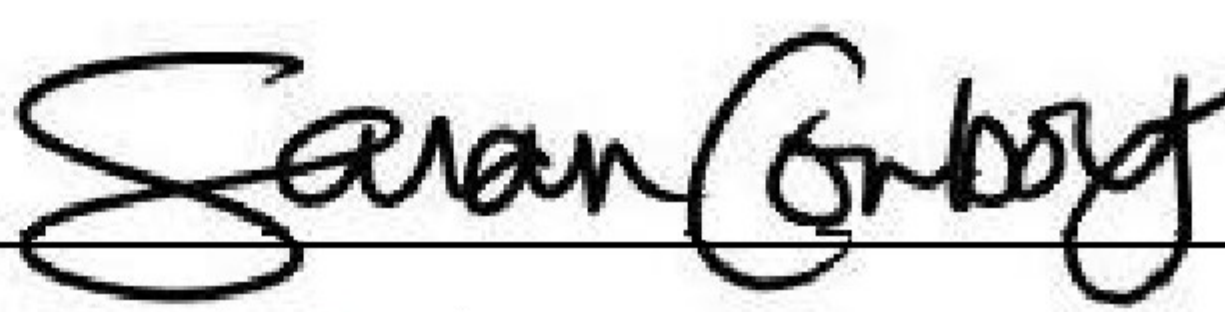
I acknowledge receipt of the Minnesota Department of Health inspection report number 8041241082 of 05/29/24.

Certified Food Protection Manager: \_\_\_\_\_

Certification Number: \_\_\_\_\_ Expires: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

Signed: \_\_\_\_\_  
Ashley Pitts

Signed:  \_\_\_\_\_  
Sarah Conboy  
Public Health San. Supervisor  
651-201-3984  
sarah.conboy@state.mn.us