DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 19, 2022

Administrator
Restful Living LLC
399 Ruth Street North
Saint Paul, MN 55119

RE: Project Number(s) SL33573015

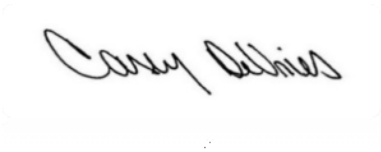
Dear Administrator:

On September 15, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the July 13, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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Electronically Delivered

August 29, 2022

Administrator
Restful Living LLC
399 Ruth Street North
Saint Paul, MN 55119

RE: Project Number(s) SL33573015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 13, 2022, 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.

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

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,500.00. 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

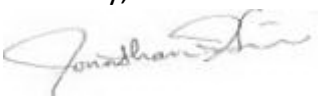
REQUESTING A HEARING

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,



Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
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St. Paul, MN 55101-3879
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HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33573	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL LIVING LLC	399 RUTH STREET NORTH SAINT PAUL, MN 55119

(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 Initial comments *****ATTENTION****** ASSISTED LIVING 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: SL33573015 On July 11, 2022, through July 13, 2022, 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 thirteen (13) residents, all of whom received services under the provider's Assisted Living license. On July 11, 2022, an immediate correction order was issued at 2310. On July 13, 2022, the immediacy of the order was removed, the scope and level of noncompliance remained the same.	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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all 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 the potential to affect a large portion or all of the residents). The findings include: On July 11, 2022, at approximately 11:30 a.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A currently held a LALD license effective through October 31, 2022; however, the website did not indicate LALD-A was listed as the Director of Record for the licensee. On July 13, 2022, at approximately 2:45 p.m., LALD-A confirmed she was the LALD for the licensee, was not listed as Director of Record for the licensee with BELTSS and was not aware of the requirement.	0 110		

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0 110	Continued From page 2 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
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 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:	0 470		

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0 470	Continued From page 3 Based on observation, interview, and record review, the licensee failed to ensure the staffing plan was posted as required, potentially affecting all the licensee's current 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 of the residents). The findings include: On July 11, 2022, at approximately 2:00 p.m. the surveyor observed the facility lacked a complete posted staff schedule during tour of the facility. The staff schedule that was posted included shift and name of employee, but lacked hours worked. On July 13, 2022, at approximately 2:45 p.m. licensed assisted living director (LALD)-A acknowledged the licensee had not completed the staffing schedule to be posted for residents, staff, and visitors in the common area. The licensee's Staffing and Scheduling policy, dated August 1, 2021, directed the licensee post a 24-hour staffing schedule that identifies staff member, shifts, days worked, hours worked, and assignments or locations for staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		

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0 480	Continued From page 4	0 480		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) 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: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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:	0 480		

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0 480	Continued From page 5 Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated July 12, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 490		

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0 490	Continued From page 6 review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all thirteen residents of the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On July 11, 2022, at approximately 10:20 a.m., during the entrance conference, the licensed assisted living director (LALD)-A stated a structured social and recreational activity was provided once weekly at the facility. On July 11, 2022, at approximately 2:00 p.m., during a facility tour, the surveyors observed no daily program of social and recreational activities posted in a common area. For the duration of the survey from July 11, 2022, through July 13, 2022, the surveyors observed one social and recreational activity provided by the licensee, a word game on July 13, 2022. On July 13, 2022, at approximately 2:45 p.m. LALD-A confirmed daily programs of social and recreational activities had not been created or implemented with the residents. LALD-A stated	0 490		

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0 490	Continued From page 7 she was not aware of the requirement to offer daily social and recreational activities. The licensee's Activity Programming policy, dated August 1, 2021, directed the licensee provide a wide range of social recreation for residents on a regular basis. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
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 infection control program that complied with accepted health care, medical and nursing standards for infection control. This had the potential to affect all thirteen (13) residents, staff, and visitors.	0 510		

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0 510	Continued From page 8 This practice resulted in a level two violation (a violation that did not harm a client'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: Hand Hygiene On July 12, 2022, at approximately 11:30 a.m., unlicensed personnel (ULP)-C was observed providing blood glucose testing for R9. ULP-C applied a pair of disposable gloves prior to entering R9's apartment on the second floor. After the blood glucose testing, ULP-C removed gloves, without hand hygiene applied a clean pair of gloves, prepared the resident's Novolog Flex Pen, administered the insulin, and placed the used equipment on a plastic tray. ULP-C returned to the medication cart on the first floor carrying the used equipment on a plastic tray. ULP-C disposed of the used needle and lancet in a bio-hazard container on the medication cart, removed gloves, and without hand hygiene applied a clean pair of gloves. ULP-C cleaned the plastic tray that carried the insulin supplies, removed gloves, and completed hand hygiene with hand sanitizer. On July 12, 2022, at approximately 3:00 p.m. licensed assisted living director (LALD)-A stated that ULP-C had been trained on proper handwashing and gloving. The licensee's 8.07 Gloves policy, dated August 1, 2021, directed staff wash their hands prior to	0 510		

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0 510	Continued From page 9 glove placement and after glove disposal. The licensee's 8.09 Hand Washing policy, dated August 1, 2021, indicated staff should complete proper hand washing techniques including, but not limited to, between tasks and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 510		
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, interview and record review, the licensee failed to post the required content in common areas to include: 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all thirteen residents receiving assisted living services, staff, and visitors.	0 640		

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0 640	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 July 11, 2022, at approximately 2:00 p.m. the surveyor observed the facility lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living facility. On July 13, 2022, at approximately 2:48 p.m. licensed assisted living director (LALD)-A confirmed the 911 emergency number was not posted in common areas or near telephones. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy, dated September 3, 2021, directed the licensee post the 911 emergency number in common areas and near telephones provided by the assisted living 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	0 680		

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	33573	A. BUILDING: _____ B. WING _____	07/13/2022

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0 680	Continued From page 11 (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 (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 observation and interview, the licensee failed to develop a written emergency disaster plan with all the required content. 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	0 680		

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0 680	Continued From page 12 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 13, 2022, at approximately 2:30 p.m. the surveyor requested and reviewed the licensee's emergency preparedness plan. The licensee's plan lacked the following required content: - current, all-hazards approach facility assessment - subsistence needs for staff and residents during emergency On July 13, 2022, at approximately 2:45 p.m. licensed assisted living director (LALD)- A confirmed the licensee did not complete a Hazardous Vulnerability Assessment and failed to calculate subsistence needs for staff and residents during emergency situations. The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy, dated August 1, 2021, indicated the licensee would have in place an effective and compliant Emergency Preparedness Plan, with the intent for the plan to align with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 790 SS=E	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	0 790		

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0 790	Continued From page 13 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 12, 2022, approximately from 10:45 a.m. to 12:15 p.m., survey staff toured the facility with the housing manager (HM)-B. During the tour, survey staff observed and the HM-B verified the	0 790		

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0 790	Continued From page 14 following findings: 1) Portable fire extinguishers were tagged showing the annual service date of April 2022, but lacked records to show the required monthly visual inspections performed for the portable fire extinguishers throughout the building. 2)The portable fire extinguisher in the sprinkler riser room was placed on the floor in the corner of the room and had not been properly mounted for ready access and visibility for use. On July 12, 2022, at approximately 1:30 p.m., the HM-B acknowledged the findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the 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 physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect	0 800		

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0 800	Continued From page 15 the health, safety, and well-being of all residents and staff. 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). The findings include: On July 12, 2022, at approximately from 10:45 a.m. to 12:15 p.m., survey staff toured the facility with the housing manager (HM)-B. During the tour, survey staff observed and the HM-B verified the following findings: 1) A small charcoal-type grill and a bottle of lighter fluid were sitting outside on the second-floor balcony near the designated smoking area where the cigarette butt receptacle was located. The HM-B explained that the resident was advised to only grill out on the main floor patio or near the parking lot. Survey staff explained that they must review with the local officials regarding open fires and the required minimum distance from the building under the Minnesota State Fire Code for the safety and well-being of all residents. 2) Large containers of cleaning chemicals and bug sprays were observed to be located in the restrooms on the main floor restrooms and in part of the corridor and were accessible and posed safety concerns to the residents. All chemicals need to be stored in a secured room or closet to ensure the safety of residents.	0 800		

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0 800	Continued From page 16 3) The back exit door was not easily operable due to rubbing on the floor when opened and closed. 4) The bathroom exhaust fans throughout the facility were dusty and needed to be cleaned. 5) Resident rooms with carpet flooring were soiled and stained. The HM-B explained that they performed deep cleaning once a year for rooms with the carpet floor but also have plans to replace the carpet with vinyl in the next few months. 6) The men's restroom on the main floor lacked proper lighting. Survey staff observed a burned-out bulb in the middle of the room. On July 12, 2022, at approximately 1:30 p.m., the HM-B acknowledged the above findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) 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,	0 810		

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0 810	Continued From page 17 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. (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 observation, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, fire safety and evacuation drills, and employee training on fire safety and evacuation. This has the potential to directly affect the safety of visitors, staff, and all residents receiving care. 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	0 810		

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0 810	Continued From page 18 of the residents). The findings include: On July 12, 2022, at approximately 12:30 p.m., survey staff received and reviewed the facility's fire safety and evacuation plan, drill, and training documentation. Documentation review indicated the following: FIRE SAFETY and EVACUATION PLAN 1) The building floor plan incorrectly showed an emergency exit route from the dining area into the commercial kitchen. 2) The fire safety and evacuation plan, and policy documents, dated August 1, 2021, lacked procedures addressing resident evacuation that included unique or unusual resident-specific needs during a fire or similar emergency evacuation. Survey staff explained to the housing manager (HM)-B that the fire policy documentation must include an evacuation plan that includes and address the types of levels of residents identified in the Annex of the facility's emergency preparedness red binder. 3) The plan and policy lacked fire protection procedures for residents. TRAINING Training documentation provided for review included staff meeting minutes dated April 20, 2022. The documentation review indicated the lack of specific training on the content of fire safety and evacuation. Survey staff explained that fire safety and evacuation training must be in addition to their emergency preparedness training provided in the minutes. FIRE AND EVACUATION DRILLS Record review indicated the licensee failed to	0 810		

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0 810	Continued From page 19 perform the minimum number of required drills. The documentation showed the last fire drill performed by employees was by means of "Table talk Scenarios" on April 20, 2022, at 3:30 p.m. for all shifts, and no drills consisting of fire and evacuation were performed in the last year. The HM-B explained that she tried to cover all three shifts where they have the most overlapped number of employees. Survey staff explained that because they have three shifts, each shift must perform their fire and evacuation drills consisting of two fire and evacuation drills per shift per year, at minimum once every other month with a minimum total of six drills in a year. The HM-B confirmed the finding and stated that they planned to carry out the required drill frequency moving forward. On July 12, 2022, at approximately 1:30 p.m., the HM-B acknowledged the above findings at the exit interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970		

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0 970	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for resident health, safety, or personal property. This had the potential to affect all residents. 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: During the entrance conference on July 11, 2022, at approximately 10:20 a.m., the surveyor requested a copy of the facility's assisted living contract. The licensee's Assisted Living Contract included a section for Liability that read, "Provider is not liable to Resident or Resident's guests for any injury, death or property damage occurring in the Apartment Unit or on Provider's premises unless such injury, death or property damage occurs as the result of and equipment malfunction or hazardous conditions within the building not caused by Resident or Resident's guests.... Resident agrees to hold Provider harmless from any and all claims for injuries, property damage or any other loss resulting from an accident or other occurrence in the Apartment Unit or on Provider's premises."	0 970		

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0 970	Continued From page 21 On July 13, 2022, at approximately 10:30 a.m., licensed assisted living director (LALD)-A confirmed the licensee's assisted living contract included the above content, stated the same contract was utilized for all residents at the facility and LALD-A was not aware of a problem with liability language in this contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete.	01530		

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01530	Continued From page 22 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 employees received the required hours of dementia care training for one of two employees (unlicensed personnel (ULP)-C) with training records reviewed. 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: The licensee provided services under an assisted living license. ULP-C had a start date of August 7, 2020, to provide direct care services to the licensee's residents. ULP-C's employee record contained evidence ULP-C had received five hours of initial dementia related training, but lacked the required eight hours of initial dementia care training within 160 working hours of the employment start date. On July 13, 2022, at approximately 2:45 p.m. the licensed assisted living director (LALD)-A confirmed the required dementia training had not	01530		

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01530	Continued From page 23 been completed. The licensee's Dementia Training policy, dated August 1, 2021, indicated direct care employees would complete eight hours of initial dementia training within 160 hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01880 SS=F	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, record review and interview, the licensee failed to ensure medications were stored according to manufacturer's recommendations for one of one medication refrigerator. 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). The findings include:	01880		

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01880	Continued From page 24 On July 12, 2022, at 11:45 a.m., the surveyor observed the medication refrigerator located on the first floor, where insulin is stored, lacked a thermometer. On July 12, 2022, at 11:45 a.m., unlicensed personnel (ULP)-C confirmed that R-9's opened and unopened NovoLog FlexPen insulin pens were stored in this medication refrigerator. The manufacturer's instructions for the Novolog FlexPen, dated March 2021, directed storing unused pens in cool storage (36-46 degrees Fahrenheit (F)) until first use, and opened pens should be stored out of the refrigerator at room temperature below 86 degrees F for up to 28 days. On July 13, 2022, at 2:45 p.m. the licensed assisted living director (LALD)-A confirmed that the licensee did not have a thermometer in the refrigerator or a temperature control log. LALD-A confirmed the licensee provided medication management services to the licensee's residents, including storage of medications. The licensee's Storage of Medications policy, dated August 1, 2021, indicated that medications would be stored per manufacturer's directions, refrigerated, room temperature, or frozen. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33573	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL LIVING LLC	399 RUTH STREET NORTH SAINT PAUL, MN 55119

(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
02310	Continued From page 25 (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for five of five residents (R1, R2, R3, R4, R5) who utilized bed rails with records reviewed. This resulted in issuance of an immediate correction order on July 11, 2022. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 July 11, 2022, at approximately 2:00 p.m., the surveyor observed bilateral half bedrails on the upper sides of R1, R3, and R5's hospital beds in the raised position. The surveyor observed portable/consumer grab bars on the upper side of R2 and R4's beds. Diagnoses for R1, R2, R3, R4 and R5 included: schizophrenia, left-side paralysis, schizoaffective disorder, vascular dementia, and left-side hemiplegia, respectively. The Service Plans for	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33573	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL LIVING LLC	399 RUTH STREET NORTH SAINT PAUL, MN 55119

(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
02310	Continued From page 26 the identified residents indicated services provided included assistance with activities of daily living and medication management. On July 11, 2022, at approximately 2:30 p.m., licensed assisted living director (LALD)-A verified the bedrails had not been assessed for safety with measurements, nor was the education provided to the resident/resident representative on the risks associated with bed rail use documented. LALD-A confirmed staff had not been trained to notify the registered nurse if bedrails were applied to a resident's bed. LALD-A verified that she had not retained the manufacturers' information for the portable/consumer grab bars, and could not ensure that the grab bars were installed or used according to manufacturers' instructions. The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy of correction order, tag identification 2310 was removed July 13, 2022,	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33573	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL LIVING LLC	399 RUTH STREET NORTH SAINT PAUL, MN 55119

(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
02310	Continued From page 27 scope and level of noncompliance remained the same.	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity. This had the potential to affect all thirteen (13) residents residing in the assisted living facility, staff, and any 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 potential to affect a large portion or all of the residents). The finding include: On July 11, 2022, at approximately 10:00 a.m.,	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33573	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RESTFUL LIVING LLC	399 RUTH STREET NORTH SAINT PAUL, MN 55119

(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
03090	Continued From page 28 the surveyor observed each facility entrance and noted the lack of signage posted with the required verbiage regarding electronic monitoring. On July 13, 2022, at approximately 2:45 p.m. the licensed assisted living director (LALD)-A verified there was signage posted indicating electronic monitoring at facility entrances, but it did not include the required verbiage regarding electronic monitoring. LALD-A stated she was not aware of the verbiage requirement. The licensee's Electronic Monitoring policy, dated August 1, 2021, directed signs be installed at each facility entrance with the required verbiage regarding electronic monitoring. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

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

Type: Full
Date: *07/12/22*
Time: 13:06:31
Report: 1021221195

Food and Beverage Establishment Inspection Report

Location:
Restful Living Llc
399 Ruth Street North
St Paul, MN55119
Ramsey County, 62

Establishment Info:
ID #: 0037881
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6514787998
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.

2-200 Employee Health

2-201.11C ** Priority 1 **

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH OWNER. AN MDH EMPLOYEE ILLNESS LOG SENT WITH REPORT.

Comply By: 07/13/22

3-700 Contaminated Food: discarded

3-701.11A ** Priority 1 **

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

A BOX OF STRAWBERRIES FOUND IN THE TRUE TWO DOOR COOLER CONTAINED MOLD. MANAGER DISCARDED STRAWBERRIES DURING INSPECTION. CORRECTED ON-SITE.

Comply By: 07/12/22

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

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

BULK CONTAINER WITH RICE WAS FOUND WITH NO LABEL. PROPERLY LABEL CONTAINER WITH THE COMMON NAME OF THE FOOD AS DESCRIBED IN RULE ABOVE.

Comply By: 07/13/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12B

MN Rule 4626.0275B Store the food preparation and dispensing utensil in a food that is not TCS food with the handles above the top of the food within containers or equipment that can be closed such as bins of sugar, flour or cinnamon.

A PLATE WAS FOUND INSIDE THE BULK CONTAINER WITH RICE. THE PLATE IS USED TO SCOOP THE RICE. PROVIDE A DISPENSING UTENSIL WITH A HANDLE.

Comply By: 07/15/22

4-500 Equipment Maintenance and Operation

4-501.19CMN

MN Rule 4626.0780C Discontinue the use of a food preparation sink for anything other than food preparation.

ESTABLISHMENT IS USING THEIR PREPARATION SINK AS A HANDWASHING SINK. SEE COMMENTS.

Comply By: 07/12/22

4-600 Cleaning Equipment and Utensils

4-601.11C

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

VENTILATION HOOD FILTERS CONTAIN ACCUMULATION OF DUST. MICROWAVE CONTAINS SPLASHING OF DRIED FOOD DEBRIS. BOTTOM SHELF IN TWO DOOR FREEZER CONTAINS DRIED FOOD DEBRIS. CLEAN AND MAINTAIN CLEAN.

Comply By: 07/16/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: MILK - CENTRAL TWO DOOR COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: YOGURT - CENTRAL TWO DOOR COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: HAM - CENTRAL TWO DOOR COOLER
Violation Issued: No

Type: Full
Date: *07/12/22*
Time: 13:06:31
Report: 1021221195
Restful Living Llc

Food and Beverage Establishment Inspection Report

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: WATERMELON - TRUE TWO DOOR COOLER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	0	4

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH KITCHEN MANAGER, SAMMIE MOUA, AND HEALTH REGULATION DIVISION NURSE EVALUATORS, ROBYN WOOLLEY AND RHONDA MAKELA.

ESTABLISHMENT CURRENTLY DOES NOT HAVE A COOK ON-SITE. THEIR FORMER COOK LEFT ON SHORT NOTICE. ESTABLISHMENT CATERS LUNCH AND DINNER FROM DIFFERENT RESTAURANTS AROUND THE AREA.

PER CONVERSATION WITH KITCHEN MANAGER, FOOD IS FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

CONTINUATION OF MN Rule 4626.0780C

ESTABLISHMENT IS USING THEIR PREP SINK AS A HANDWASHING SINK. THERE ARE WHOLE FRUITS AND VEGETABLES IN THE TWO DOOR COOLER. PER CONVERSATION WITH KITCHEN STAFF, THEY WASH THEIR PRODUCE IN ONE OF THE COMPARTMENTS OF THE THREE COMPARTMENT SINK. THEY DO SANITIZE THE COMPARTMENT BEFORE AND AFTER USING IT.

ESTABLISHMENT HAS A HANDWASHING SINK BUT IT IS LOCATED IN THE DRY STORAGE AREA. STAFF WILL USE THE HANDWASHING SINK TO WASH HANDS AND THEY WILL USE THE PREP SINK TO WASH ANY PRODUCE.

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 1021221195 of 07/12/22.

Certified Food Protection Manager SAMMIE T. MOUA

Certification Number: FM108392 Expires: 11/05/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
SAMMIE MOUA
KITCHEN MANAGER

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us