



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 19, 2024

Licensee
Skyview Housing Inc
670 Heinel Drive
Roseville, MN 55113

RE: Project Number(s) SL40494015

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.

The Minnesota Department of Health completed an initial survey on November 14, 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.

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 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,



Renee L. Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER SKYVIEW HOUSING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 670 HEINEL DRIVE ROSEVILLE, MN 55113		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40494015-0 On November 12, 2024, through November 14, 2024, 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 2 residents, both of whom were receiving services under the provider's Assisted Living Facility provisional license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 110	Continued From page 1 and Supports. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed in the Board of Executives for Long-Term Services and Supports (BELTSS) directory 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 one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 13, 2024, at 11:30 a.m., registered nurse/licensed assisted living director (RN/LALD)-A stated she was not listed in BELTSS as the director of record for the licensee and was in the process of affiliating herself. On November 13, 2024, at 12:00 p.m., the surveyor observed the BELTSS website and verified RN/LALD-A was licensed as an assisted living director and not affiliated with the licensee. The licensee's Shared Assisted Living Director & Delegation of Authority Policy & Procedure policy, dated March 16, 2024, indicated within 15 days after assuming the position, the LALD would	0 110			

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0 110	Continued From page 2 submit an application to serve as a shared director to the BELTSS. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 640	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support resident protection and safety by not ensuring information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) were posted. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 640			

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0 640	Continued From page 3 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: During a facility tour on November 12, 2024, at 10:00 a.m., the surveyor observed the common areas shared by residents, staff, and visitors. The area lacked the required posting of the contact information related to reporting suspected maltreatment to MAARC. On November 12, 2024, at 12:20 p.m., registered nurse/licensed assisted living director (RN/LALD)-A verified the licensee lacked posting of the above required information. LALD-A stated she thought she had posted all required information but must have missed the MAARC posting. The licensee's Vulnerable Adult Policy and Procedure policy, dated March 16, 2024, indicated the licensee would post contact information for the MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	0 660			

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0 660	Continued From page 4 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 volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) 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 maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA) blood test was completed and documented for one of two employees (registered nurse/licensed assisted living director (RN/LALD)-A). 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:	0 660			

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0 660	Continued From page 5 The licensee's TB facility risk assessment, dated February 28, 2024, indicated the facility was a "low" risk for TB transmission. RN/LALD-A was hired September 27, 2023, to provide direct cares and services to residents, supervise staff and perform managerial duties. On November 12, 2024, to November 13, 2024, during the survey period, RN/LALD-A was observed supervising staff and performing managerial duties in the facility. RN/LALD-A's employee record contained an IGRA blood test, dated December 10, 2022, greater than 90 days (291 days) prior to hire. On November 13, 2024, at 11:30 a.m., RN/LALD-A stated she did not realize a blood test could not be more than 90 days before hire. RN/LALD-A further stated she misunderstood the guidelines and thought she only needed one. 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 the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST-tuberculin skin test (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the	0 660			

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0 660	Continued From page 6 employee's record. The licensee's Tuberculosis Screening/Prevention Policy & Procedure policy, dated March 16, 2024, indicated baseline testing would be completed upon hire and would consist of either a two-step TST or single IGRA blood test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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	0 680			

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0 680	Continued From page 7 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview, and record review the licensee failed to have a written emergency preparedness (EP) plan with all 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 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's undated EP plan lacked the following required content: -subsistence needs for staff and residents during emergency situation; - a written risk assessment utilizing an all-hazards approach; -development of all policies and procedures, based on risk assessment; -a communication plan with the following required content: names and contact information for staff/entities providing services under an agreement, residents' physicians, other facilities, volunteers. On November 13, 2024, at 10:30 a.m., housing manager/unlicensed personnel (HM/ULP)-B	0 680			

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0 680	Continued From page 8 stated the EP manual had not been developed to include all the required information, and the licensee had not done the hazard risk assessment. The licensee's Emergency Preparedness *Policy & Procedure policy, dated June 16, 2024, indicated the licensee would have an identified plan in place to ensure the safety and well-being of residents and staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (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 and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors.	0 790			

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0 790	Continued From page 9 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 November 12, 2024, from 12:30 p.m. to 1:45 p.m., the surveyor toured the facility with housing manager and unlicensed personnel (HM/ULP)-B. The portable fire extinguishers throughout the facility lacked records to show monthly visual inspections were complete. Documentation is required to demonstrate facility personnel have inspected fire extinguishers monthly. On November 12, 2024, at 1:00 p.m., the surveyor explained to HM/ULP-B that the portable fire extinguishers must be provided monthly visual inspections or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. HM/ULP-B stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			

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0 810	Continued From page 10	0 810			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the	0 810			

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0 810	Continued From page 11 licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 12, 2024, registered nurse/licensed assisted living director (RN/LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated September 25, 2023, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic	0 810			

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0 810	Continued From page 12 evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. RN/LALD-A has completed resident assessments that were in the individual resident folders. RN/LALD-A was advised that individualized assessments for unique resident needs need to be included in the FSEP. RN/LALD-A stated that they understood and would add the individualized assessments to the FSEP. On November 12, 2024, at 2:15 p.m., RN/LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. RN/LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. RN/LALD-A stated that they have trained residents on the policy but was unable to produce any record of the trainings. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. No other training documentation was provided. RN/LALD-A stated that they have trained staff on the policy but was unable to produce any record of the trainings.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 40494	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/14/2024
NAME OF PROVIDER OR SUPPLIER SKYVIEW HOUSING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 670 HEINEL DRIVE ROSEVILLE, MN 55113		
(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	
0 810	Continued From page 13 On November 12, 2024, at 2:15 p.m., RN/LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			



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

Type: Full
Date: 11/12/24
Time: 13:15:00
Report: 1005241295

Food and Beverage Establishment Inspection Report

Page 1

Location:

SKYVIEW HOUSING INC
670 HEINEL DRIVE
Roseville, MN55113
Ramsey County, 62

Establishment Info:

ID #: 0043788
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 180+ Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/SOUP
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH NURSING DIRECTOR AND REVIEWED WITH HRD NURSE EVALUATOR TAMMY CARLSON.

FACILITY HAS THERMOLABELS FOR THE DISHWASHER AND IT IS TESTED WEEKLY. A STRIP WAS JUST RUN THROUGH THE DISHWASHER THIS MORNING AND ACHIEVED A UTENSIL SURFACE TEMPERATURE OF 180+ DEGREES F.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

Type: Full
Date: 11/12/24
Time: 13:15:00
Report: 1005241295
SKYVIEW HOUSING INC

Food and Beverage Establishment Inspection Report

Page 2

CABINETS ARE WOOD WITH HOLLOW BASE AND COUNTERS ARE LAMINATE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 1005241295 of 11/12/24.

Certified Food Protection Manager: DEGA M. HASSAN

Certification Number: FM120470 Expires: 10/30/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

RAWI DORE
NURSING DIRECTOR

Signed: _____



Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us