Electronically Delivered

April 17, 2025

Licensee
St Mark's Heritage Community
400 15th Avenue Southwest
Austin, MN 55912

RE: Project Number(s) SL30839016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 21, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH 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.

MDH 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. MDH 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 may be 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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with 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 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(s) 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 MDH 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

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

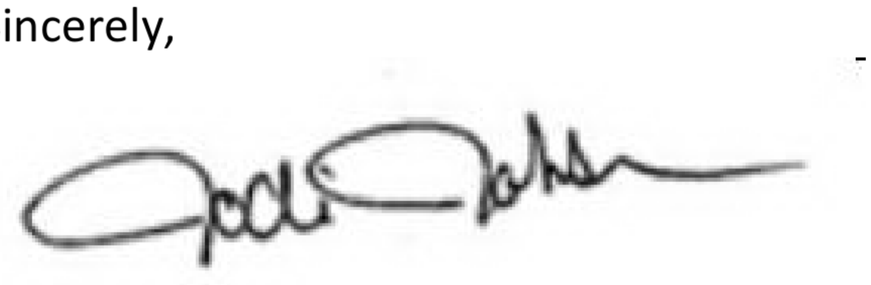
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30839	A. BUILDING: _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARK'S HERITAGE COMMUNITY	400 15TH AVENUE SW AUSTIN, MN 55912

(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 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: SL30839016-0 On March 17, 2025, through March 21, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 46 residents; 42 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for	0 470		

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0 470	Continued From page 1 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: Based on observation, interview, and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents. In addition, the licensee failed to ensure the staffing schedule was posted with the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 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 held an Assisted Living with Dementia Care license for a bed capacity of 54 residents. At the time of the survey, there were 46 residents; 42 receiving services under the Assisted Living Facility with Dementia Care license. STAFFING PLAN During the entrance conference on March 17, 2025, at 11:00 a.m., executive director (ED)-A and clinical nurse supervisor (CNS)-B stated there were five unlicensed personnel (ULP) scheduled for 7:00 a.m. to 3:00 p.m., five ULP scheduled for 3:00 p.m. to 11:00 p.m., one ULP scheduled from 4:00 p.m. to 9:00 p.m., and three ULP scheduled from 11:00 p.m. to 7:00 a.m. On March 20, 2025, at 9:14 a.m., CNS-B stated there had been a change in management and did not know what happened to the staffing plan. CNS-B indicated it had been done but was unable to provide or locate the licensee's staffing plan. DAILY STAFF SCHEDULE POSTING During a tour of the facility on March 17, 2025, at 12:02 p.m., the licensee's staffing form was posted on a bulletin board in the hallway of the assisted living and on a bulletin board inside the	0 470		

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0 470	Continued From page 3 entrance of the secured unit. The form listed the dates of December 4, 2024, through January 3, 2024, unlicensed personnel (ULP) shift start and end times. It also listed the registered nurse (RN), licensed practical nurse (LPN), and on-call RN shift start and end times. However, the form lacked the correct dates and did not identify the direct-care staff member's work location. On March 17, 2025, at 1:55 p.m., CNS-B stated the posted schedule did not include the date or work location of staff. CNS-B indicated someone else had developed the form and was not aware of the posting requirement. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 3., effective January 13, 2025, the CNS must develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24 hours a day, seven days a week. When developing a direct-care staffing plan, the CNS must ensure that staffing levels are adequate to address the following: A. each resident's needs, as identified in the resident's service plan and assisted living contract; B. each resident's acuity level, as determined by the most recent assessment or individualized review; C. the ability of staff to timely meet the residents' scheduled and reasonable foreseeable unscheduled needs given the physical layout of the facility premises; D. whether the facility has a secured dementia care unit; and E. staff experience, training, and competency. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective January	0 470		

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0 470	Continued From page 4 13, 2025, the CNS must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. The daily staffing schedule must be posted, after reacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The licensee's 3.75 Staffing & Scheduling policy dated August 1, 2021, noted the clinical nurse supervisor would develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the resents' needs 24-hours a day, seven-days a week. In addition, the policy included the the clinical nurse supervisor would develop a 24-hour daily staffing schedule that would identify: a. direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; and b. the direct-care staff member's resident assignments or work location. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the	0 480		

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0 480	Continued From page 5 Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;	0 480		

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0 480	Continued From page 6 (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 21, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		

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0 660	Continued From page 7	0 660		
0 660 SS=D	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 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 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 documentation of a completed health history and symptom screening, for one of two employees (unlicensed personnel (ULP)-D). 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	0 660		

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0 660	Continued From page 8 situation has occurred only occasionally). The findings include: The facility's TB risk assessment dated July 19, 2024, indicated the licensee was "low risk". ULP-D began providing direct care service for the licensee on November 26, 2024. On March 18, 2025, at 8:53 a.m., the surveyor observed ULP-D administer medications to R2. ULP-D's record contained a negative two-step tuberculin skin test (TST) dated November 29, 2024, and December 11, 2024; however, ULP-D's employee record lacked a TB history and symptom screen. On March 20, 2025, at 9:16 a.m., clinical nurse supervisor (CNS)-B stated ULP-D was lacking a TB history and symptom screen. The licensee's 8.07 Tuberculosis & Staff Screening policy dated revised August 2024, noted new personnel, to include previous staff that are a rehire, shall be screened for active signs of TB using the baseline TB screening tool for health care workers. 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 an employee may begin working with residents after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may	0 660		

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0 660	Continued From page 9 be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current Minnesota Fire Code Provisions. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on March 18, 2025, from 11:44 a.m. through 12:59 p.m., with executive director (ED)-A and director of maintenance (DM)-F, the surveyor observed exit doors in the North pod	0 775		

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0 775	Continued From page 10 and South pod of the memory care wing that were equipped with magnetic locks that required a code to unlock. DM-F stated the doors would unlock when the fire alarm was activated and that they were also delayed egress. DM-F pushed the doors to open and within fifteen seconds the doors released. The doors did not have a sign that indicates the delayed egress function and were not capable of being deactivated at the fire command center or other approved location as required by State Fire Code in Minnesota Rules, chapter 7511. The North pod exit door opened into a fenced area that had a locked gate. DM-F stated the gate lock was not connected to the building fire alarms and would not unlock when the fire alarms activated. State Fire Code in Minnesota Rules, chapter 7511 requires that emergency exits provide a direct and unobstructed access to a public way. ED-A and DM-F verified the above findings while accompanying on the tour and stated they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
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) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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ST MARK'S HERITAGE COMMUNITY	400 15TH AVENUE SW AUSTIN, MN 55912

(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 11 (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) Staff 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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. 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	0 810		

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0 810	Continued From page 12 or has potential to affect a large portion or all of the residents). The findings include: On March 18, 2025, at 1:00 p.m., director of maintenance (DM)-F provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The evacuation map included in the FSEP did not show evacuation routes or emergency exits. The resident room numbers in the memory care wing did not match the room numbers shown on the evacuation map. There were no resident room numbers on the evacuation map for the assisted living area. The licensees FSEP titled, Tab #17-Fire Emergency-Internal & External, undated, lacked the following required content: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. During an interview on March 18, 2025, at 1:53 p.m., DM-F stated they understood the areas of the plan that needed to be updated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must	01500		

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01500	Continued From page 13 complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must	01500		

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01500	Continued From page 14 include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of four employees (unlicensed personnel (ULP)-E). 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: ULP-E was hired on February 12, 2024, to provide direct care services under the licensee's assisted living with dementia care license.	01500		

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01500	Continued From page 15 ULP-E's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: -review of infection control techniques; and -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On March 21, 2025, at 2:45 p.m., clinical nurse supervisor (CNS)-B stated ULP-E's employee filed lacked the required annual training as noted above. The licensee's 10.08 Required Annual Training policy dated August 1, 2021, included the following training elements must be included every 12 months to all staff who performs direct care services: 3. Review of infection control techniques used and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases. 5. Review of the site policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		

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01620	Continued From page 16	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed ongoing resident reassessments that did not exceed 90 days for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01620		

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01620	Continued From page 17 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included neurocognitive disorder (problems with thinking, reasoning, memory, and problem solving) and dementia. R2's Addendum to Contract - Private - MN (identified as the service plan) dated effective October 17, 2024, indicated R2 received services including assistance with bathing, compression stockings, dressing, grooming, toileting, transfers, and medication administration. R2's record included assessments dated October 8, 2024, October 14, 2024, and January 13, 2025. The January 13, 2025, assessment was 91 days after the last date of the assessment on October 14, 2024, thus exceeding 90 calendar days. On March 20, 2025, at 9:32 a.m., clinical nurse supervisor (CNS)-B stated R2's assessment was late as noted above. CNS-B stated the computer software program notified when assessments were due, but going forward would schedule them a week ahead to give herself a buffer on the due dates. The licensee's 11.01 Assessments, Reviews & Monitoring policy dated revised August 2024, noted: 3. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last	01620		

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01620	Continued From page 18 date of the assessment. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the licensee failed to have specified, in writing, specific instructions for each resident and documented those instructions for one of three residents (R2) for medication administration delegated to unlicensed personnel. In addition, the licensee failed to document the site of injection for one of one resident (R1) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	01750		

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01750	Continued From page 19 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 R2's record lacked specific written instructions regarding the administration of as needed (PRN) medications. R2's diagnoses included neurocognitive disorder (problems with thinking, reasoning, memory, and problem solving) and dementia. R2's Addendum to Contract - Private - MN (identified as the service plan) dated effective October 17, 2024, included medication administration. R2's prescriber orders dated August 1, 2024, included: -naproxen sodium (for pain) 220 milligrams (mg) two tablets (440 mg) twice daily as needed (PRN) for headache, pain, or fever. R2's prescriber orders dated September 10, 2024, included: -tramadol (for severe pain) 25 mg every 6 hours PRN for pain. The licensee failed to have instructions regarding when each medication for pain (naproxen sodium and tramadol) were to be given. On March 20, 2025, at 9:29 a.m., clinical nurse supervisor (CNS)-B stated there were no specific instructions for R2's PRN pain medications. R1 R1's diagnoses included diabetes.	01750		

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01750	Continued From page 20 R1's Service Plan - Waiver3 - MN dated effective December 23, 2024, included medication administration. R1's prescriber orders dated December 17, 2024, included an order for insulin aspart (fast-acting) FlexPen 24 units under the skin daily before morning meal, 10 units before midday meal, and 19 units before evening meal with sliding scale after testing blood sugar. 180-219 = 2 units, 220-259 = 3 units, 260-299 = 4 units, 300-339 = 5 units, 340-379 = 6 units, 380-399 = 7 units, greater than or equal to 400 = 8 units and call your provider. R1's medication administration record (MAR) dated March 2025, included the order for insulin aspart FlexPen as noted above. The medication sheet included a spot for each date and staff initials to indicate the medication had been administered. However, it lacked a space to indicate the site the insulin was administered on the resident's body. On March 18, 2025, at 10:53 a.m. the surveyor observed unlicensed personnel (ULP)-E administer R1's insulin aspart. ULP-E then returned to the medication cart to document the insulin aspart administration; however, no location was documented. ULP-E stated there was not an area for her to document this but stated she rotated the injection site between the morning and noon administration. On March 20, 2025, at 9:50 a.m. CNS-B stated the location of insulin injections should be documented and she would need to update R1's MAR to include this information.	01750		

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01750	Continued From page 21 NovoLog FlexPen (insulin aspart FlexPen) Instructions for use dated revised February 2023, noted: Change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidsis (skin with lumps) at the injection sites. Do not use the same injection site for each injection. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the prescription label matched the order for one of four residents (R2) observed during medication administration. 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	01890		

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01890	Continued From page 22 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included neurocognitive disorder (problems with thinking, reasoning, memory, and problem solving) and dementia. R2's Addendum to Contract - Private - MN (identified as the service plan) effective October 17, 2024, included medication administration. R2's prescriber orders dated October 21, 2024, included: - polyethylene glycol (laxative) 17 gram by mouth daily, dissolve in 8 ounces of beverage. R2's medication administration record (MAR) dated March 2025, included the medication as ordered above. On March 18, 2025, at 8:53 a.m., the surveyor observed unlicensed personnel (ULP)-D administer polyethylene glycol to R2. The polyethylene glycol had a label that directed to administer everyday as needed (PRN). When interviewed at this time, ULP-D stated the label for R2's polyethylene glycol did not match the MAR but said she would follow the MAR instead of the label. On March 18, 2025, at 9:46 a.m., clinical nurse supervisor (CNS)-B stated the prescription label should match the current prescriber orders and MAR. CNS-B stated ULP-D should have notified the nurse of the discrepancy, and there should have been a "see MAR" sticker applied to the prescription label.	01890		

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01890	Continued From page 23 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940		

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01940	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: During the entrance conference on March 17, 2025, at 11:00 a.m., executive director (ED)-A and clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services to their residents. R1 R1's diagnoses included diabetes. R1's Service Plan - Waiver3 - MN dated effective December 23, 2024, indicated R1 received assistance with compression stockings (socks used to increase circulation and reduce swelling in the legs). On March 18, 2025, at 7:30 a.m., the surveyor observed unlicensed personnel (ULP)-E apply R1's bilateral compression socks.	01940		

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01940	Continued From page 25 R1's prescriber orders dated December 17, 2024, included an order for compression stockings. R1's Services Delivered dated March 2025, included documentation R1 had assistance with compression stockings in the morning and at bedtime. R1's Individualized Treatment Plan dated December 23, 2024, failed to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. R2 R2's diagnoses included neurocognitive disorder (problems with thinking, reasoning, memory, and problem solving) and dementia. R2's Addendum to Contract - Private - MN (identified as the service plan) effective October 17, 2024, indicated R1 received assistance with compression stockings. On March 18, 2025, at 9:09 a.m., the surveyor observed ULP-D apply R2's bilateral ACE (all cotton elastic) compression wraps. R2's prescriber orders dated October 8, 2024, included ACE wraps (compression wrap), 4 inch wide, on bilateral lower extremities, on in the a.m. and off in p.m. for peripheral edema. R2's Services Delivered dated March 2025, included documentation R2 received assistance with compression stockings in the morning and at bedtime. R2's treatment plan dated October 11, 2024,	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30839	A. BUILDING: _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARK'S HERITAGE COMMUNITY	400 15TH AVENUE SW AUSTIN, MN 55912

(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
01940	Continued From page 26 failed to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. R3 R3's diagnoses included dementia and edema (swelling from fluid in body tissues). R3's unsigned Service Plan - Private Pay - MN effective November 15, 2024, indicated R3 received assistance with compression stockings. On March 18, 2025, at 12:40 p.m., the surveyor observed R3 wearing bilateral compression stockings. R3's prescriber orders dated December 26, 2024, included orders for bilateral compression socks. R3's Services Delivered dated March 2025, included documentation R3 had assistance with compression stockings in the morning and at bedtime. R3's treatment plan dated August 25, 2024, failed to include the following required content: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. On March 20, 2025, at 9:39 a.m., CNS-B stated R1, R2, and R3's record lacked a treatment management plan to include all the required content as noted above. CNS-B stated she had not included the component for any resident receiving treatments and was not aware of the requirement. The licensee's 12.07 Treatment & Therapy	01940		

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	30839	A. BUILDING: _____ B. WING _____	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARK'S HERITAGE COMMUNITY	400 15TH AVENUE SW AUSTIN, MN 55912

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01940	Continued From page 27 Management Plan policy dated August 1, 2021, indicated the licensee would develop and maintain a current individualized treatment and therapy management record for each resident which would contain the following: - procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability to affect all staff,	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30839	A. BUILDING: _____ B. WING _____	03/21/2025

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ST MARK'S HERITAGE COMMUNITY	400 15TH AVENUE SW AUSTIN, MN 55912

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02040	Continued From page 28 residents, 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). Findings include: On March 18, 2025, at 1:00 p.m., director of maintenance (DM)-F provided documents on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During an interview on March 18, 2025, at 1:53 p.m., DM-F verified that the licensee was not able to provide a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. On March 20, 2025, at 11:56 a.m., executive director (ED)-A emailed the surveyor documents on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had performed a hazard vulnerability assessment on and around the property that identified potential hazards. The document lacked mitigation factors for the	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30839	A. BUILDING: _____ B. WING _____	03/21/2025

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02040	Continued From page 29 identified hazards. On March 20, 2025, at 1:48 p.m. the surveyor replied to ED-A by email that the documents provided lacked mitigation factors for the identified hazards. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered according to policy and accepted standards of practice by one of four staff (unlicensed personnel (ULP)-D) observed during medication administration. 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	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30839	A. BUILDING: _____ B. WING _____	03/21/2025

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02320	Continued From page 30 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's diagnoses included neurocognitive disorder (problems with thinking, reasoning, memory, and problem solving) and dementia. R2's Addendum to Contract - Private - MN (identified as the service plan) effective October 17, 2024, included medication administration. R2's prescriber orders dated September 10, 2024, included an order for diclofenac (generic name for Voltaren) (arthritis pain gel) 1% external gel (topical nonsteroidal anti-inflammatory drug). Apply 4 g (grams) topically to right hip, knee, ankle twice daily for pain. R2's medication administration record (MAR) dated March 2025, included arthritis pain 1% topical gel apply 4 g topically to right hip, knee, and ankle twice daily. On March 18, 2025, at 8:53 a.m., the surveyor observed ULP-D prepare and administer medications to R2. ULP-D reviewed R2's MAR, sanitized hands, donned clean gloves, and placed a pea sized amount of R2's Voltaren 1% gel to her gloved hand. ULP-D applied a pea sized amount of gel to R2's right hip, knee and ankle. ULP-D did not measure the amount of Voltaren gel applied. Following the application of the gel, ULP-D removed gloves, sanitized hands, and documented the Voltaren 1% gel administration. When interviewed at this time, ULP-D stated she did not utilize the measuring device because the nurse had told her it was inaccurate.	02320		

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02320	Continued From page 31 On March 18, 2025, at 9:46 a.m., clinical nurse supervisor (CNS)-B stated staff were taught and instructed to use the measuring device that comes with the Voltaren gel for an accurate measurement of the medication. The Voltaren instructions for use revised May 2016, identified to use the dosing card to correctly measure each dose. Place the dosing card on a flat surface so that you can read the print. Squeeze the gel onto the dosing card evenly, up to the 4 g line (a 4.5-inch length of gel). Make sure that the gel covers the 4 g area of the doing card. After using the dosing card, hold end with fingertips, rinse and dry. Store the dosing card until next use. The licensee's 12.11 Medication Management: Administration & Setup policy revised August 2024, noted ULP trained to provide medication administration will document any medication administration provided accurately in each resident record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Minnesota Department of Health
Environmental Health - FPLS

Rochester

Type: Full
Date: *03/21/25*
Time: 12:18:06
Report: 1038251048

Food and Beverage Establishment Inspection Report

Location:
St Mark'S Heritage Community
400 15th Avenue Sw
Austin, MN55912
Mower County, 50

Establishment Info:
ID #: 0038382
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074347237
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.

4-700 Sanitizing Equipment and Utensils

4-703.11C ***** Priority 1 *****

MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.

DISHWASHER DID NOT REACH APPROVED TEMP AFTER THREE ATTEMPTS
Comply By: 03/21/25

6-200 Physical Facility Design and Construction

6-202.11A

MN Rule 4626.1375A Provide effective shielding, coated or shatter-resistant light bulbs for all light fixtures where there is exposed food, clean equipment, utensils and linens, or unwrapped single-service or single-use articles.

LIGHT COVER OVER OVEN IS DAMAGED
Comply By: 03/21/25

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.
LIGHT BURNED OUT IN KITCHEN

HAND WASHING SINK NOT SEALED TO WALL
Comply By: 03/21/25

Type: Full
Date: *03/21/25*
Time: 12:18:06
Report: 1038251048
St Mark'S Heritage Community

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400ppm at Degrees Fahrenheit
Location: Three Compartment sink
Violation Issued: No

Hot Water: = at 156 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: Yes

Food and Equipment Temperatures

Process/Item: Walk-In Freezer
Temperature: 0 Degrees Fahrenheit - Location: Beef
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: Milk
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: Butter
Violation Issued: No

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Bread
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location:
Violation Issued: No

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

DIRECTED STAFF TO SANITIZE FOOD WERE ITEMS IN THREE COMPARTMENT SINK UNTIL DISHWASHER IS REPAIRED.
dining_director@stmarksliving.org

Type: Full
Date: *03/21/25*
Time: 12:18:06
Report: 1038251048
St Mark'S Heritage Community

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1038251048 of 03/21/25.

Certified Food Protection Manager: Tammy Wallace

Certification Number: FM20011 Expires: 06/27/27

Signed: _____
Establishment Representative

Signed: _____

Rob Davis
Sanitarian 2
Rochester District Office
507-810-9902
rob.davis@state.mn.us