



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 19, 2024

Licensee
Home Front First
224 North 19th Street
Montevideo, MN 56265

RE: Project Number(s) SL21051015

Dear Licensee:

On July 3, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 3, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 24, 2024

Licensee
Home Front First
224 North 19th Street
Montevideo, MN 56265

RE: Project Number(s) SL21051015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 3, 2024, 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.

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 . . ."

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

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>

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST			STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265		
(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: SL21051015-0 On April 1, 2024, through April 3, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 21 resident(s); 21 receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST		STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265			
(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 1 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. This had the potential to affect all staff, residents, and visitors.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST		STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265			
(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 2 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: During an interview on April 3, 2024, at 3:35 p.m., director of maintenance (DM)-H provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Emergency evacuation map of the facility lacked details on where the emergency exits are located. Current emergency evacuation map was hard to follow. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month for employees as required by statute. Documentation showed evacuation drills being done on a quarterly basis. DM-H verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment	0 820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST			STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265		
(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
0 820	Continued From page 3 (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee had locking arrangements on the outside of a storage, bathroom, and office doors this did not constitute a distinct hazard to life but 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) 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). On April 3, 2024, at 2:45 p.m. survey staff toured the facility with the director of maintenance (DM)-H. It was observed, in house one, that the bathroom, storage and office doors had a latch style door lock that locked from the hallway side. This was on the outside which would allow	0 820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST		STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265			
(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
0 820	Continued From page 4 anyone in the facility to lock the door, trapping another person inside these rooms. Survey staff explained to DM-H that the latch style door locks on the hallway side constituted an obstruction of egress and the resident's safety. DM-H verbally confirmed survey staff observations during the facility tour. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 820			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST		STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265			
(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
01440	Continued From page 5 performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two unlicensed personnel (ULP-G). 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-G was hired on June 19, 2023, to provide direct care services to residents at the assisted living. ULP-G's employee record lacked documentation of a RN supervising ULP-G performing delegated tasks within 30 days of beginning work with the licensee. On April 3, 2024, at 2:24 p.m. licensed assisted living director in residence (LALDIR)-A stated ULP-G had been doing delegated tasks since July 22, 2023, and lacked the required 30-day supervision of delegated tasks as required. The licensee's 11.23 Supervision of Personnel - Delegated Services policy dated August 1, 2021, noted direct supervision of staff performing delegated tasks must be provided within 30	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST		STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265			
(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
01440	Continued From page 6 calendar days after the date on which the individual begins working and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST			STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265		
(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
01640	Continued From page 7 review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On April 2, 2024, at 9:34 a.m. R2 was observed sitting in her recliner chair in her room wearing oxygen at 2 liters per minute (LPM). R2's diagnoses included chronic obstructive pulmonary disease (COPD) (progressive lung disease with respiratory symptoms and airflow limitations), asthma (airways narrow and swell), emphysema (lung condition causing shortness of breath) bipolar (mental disorder), and paranoid schizophrenia (mental disorder in which people interpret reality abnormally). R2's Service Plan (Waiver) dated January 29, 2024, indicated the resident received medication administration services provided by unlicensed personnel (ULP) eight times daily. The service plan failed to identify the treatment of oxygen administration. R2's prescriber orders dated February 5, 2023, included an order for continuous oxygen 2 LPM. R2's medication administration record (MAR)	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST		STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265			
(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
01640	Continued From page 8 dated April 2024, included staff initials for oxygen 2 LPM via nasal cannula continuously; needs to remove oxygen prior to smoking. R2's Resident Service Recap dated March 25, 2024, to April 2, 2024, included staff initials each shift for oxygen maintenance. On April 2, 2024, at 2:14 p.m. registered nurse (RN)-D stated R2's service plan lacked the treatment of oxygen administration. RN-D indicated when changes are put into the system, a new service plan is generated to be signed; however, R2's record lacked this. The licensee's 12.07 Treatment & Therapy: Management Plan dated August 1, 2021, noted: For each resident receiving management of ordered or prescribed treatments or therapy services, the site will prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
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;	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST			STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265		
(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
01750	Continued From page 9 (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 observation, interview, and record review, the licensee failed to ensure delegated procedures were followed for two of four residents (R2, R3) 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 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 R2's diagnoses included chronic obstructive pulmonary disease (COPD) (progressive lung disease with respiratory symptoms and airflow limitations), asthma (airways narrow and swell), emphysema (lung condition causing shortness of breath) bipolar (mental disorder), and paranoid schizophrenia (mental disorder in which people interpret reality abnormally). R2's Service Plan (Waiver) dated January 29, 2024, indicated the resident received medication administration services provided by unlicensed personnel (ULP) eight times daily.	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST			STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265		
(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
01750	Continued From page 10 R2's prescriber orders dated December 26, 2023, included an order for Wixela Inhub (bronchodilator) 250 micrograms (mcg)-50 mcg 1 puff twice a day (take this inhaler 2nd, wait 5 minutes after Spiriva inhaler) (bronchodilator) and rinse mouth afterwards. R2's medication administration record (MAR) dated April 2024, included an order for Wixela Inhub 250 mcg-50 mcg 1 puff twice a day (take this inhaler 2nd, wait 5 minutes after Spiriva) and rinse mouth afterwards. On April 2, 2024, at 8:38 a.m., unlicensed personnel (ULP)-E was observed administering medications to R2. After R2 took her scheduled Spiriva, ULP-E took R2's blood pressure and then gave her the scheduled oral medications. After R2 swallowed all oral medications, (about 5 minutes later) ULP-E handed the resident her Wixela Inhub inhaler. R2 took the inhaler and independently administered one puff. When finished, R2 handed the inhaler back to ULP-E. R2 made no attempt to rinse her mouth nor did ULP-E prompt the resident to rinse her mouth afterwards. On April 2, 2024, at 1:53 p.m. ULP-E stated she did not prompt or have R2 rinse her mouth after utilizing the inhaler. ULP-E stated she was not aware of the requirement and did not realize the MAR directed to do so. R3 R3's diagnosis included diabetes. R3's Service Plan (Waiver) dated July 1, 2023, indicated the resident received medication administration services provided by ULP five	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST			STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265		
(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
01750	Continued From page 11 times daily. R3's prescriber orders dated January 3, 2024, included an order for Novolog (fast-acting insulin that lowers blood sugar) 10 units subcutaneous before breakfast. Prime 2 units and waste them, dial dose, inject resident, come back and put needle in sharps container, and chart. R3's MAR dated April 2024, included an order for Novolog give 10 units before breakfast. Prime 2 units and waste them, dial dose, inject resident, come back and put needle in sharps container, and chart. R3's most recent Individualized Medication Management Plan dated January 29, 2024, noted medications were administered by staff following the MAR as scheduled. Staff are to contact nursing with any questions, concerns or discrepancies. Resident is insulin dependent. Staff administer insulin per prescriber orders. Resident applies and removes insulin cap per preference. On April 3, 2024, at 7:58 a.m. the surveyor observed ULP-E administer R3's oral medications and prompt him to do his blood sugar check. After R3 independently checked his blood sugar, ULP-E handed R3 his Novolog FlexPen and a new needle. R3 removed the cap, then attached the needle to the port of the pen. R3 did not cleanse the pen port with alcohol prior to attaching the needle to the pen. R3 dialed the pen to the prescribed 10 units (without priming the pen first) and administered the insulin into his right abdomen. Following the injection, R3 handed the insulin pen back to ULP-E and she disposed of the needle into a sharps container, and brought the pen back to the medication cart	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST			STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265		
(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
01750	Continued From page 12 and charted the medication administration. ULP-E stated she did not prep the FlexPen because R3 "gets mad". ULP-E further stated she had previously reported this to the nurse. On April 2, 2024, at 2:19 p.m. registered nurse (RN)-D stated ULP-E should have prompted R2 to rinse mouth after inhaler use. In addition, RN-D stated she was not aware R3 was completing all aspects of his insulin administration but stated he should be cleansing the pen hub and doing a 2-unit waste just like if staff were administering. RN-D stated ULP-E should have prompted R3 in the correct procedure and notified the RN MAR instructions were not being followed. The manufacturer Wixela Inhub Patient Information insert and Instructions for Use revised August 2022, indicated: Rinse your mouth with water after breathing in the medicine. Spit out the water. Do not swallow it. The manufacturer Novolog FlexPen Patient Information insert and Instructions for Use revised April 2015, indicated: A. Pull off the pen cap. Wipe the rubber stopper with an alcohol swab. B. Remove the protective tab from a disposable needle. C. Pull of the big outer needle cap. D. Pull of the inner needle cap and dispose of it. E. Turn the dose selector to select 2 units. F. Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. If	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST		STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265			
(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
01750	Continued From page 13 you do not see a drop of insulin after 6 times, do not use the Novolog FlexPen and contact Novo Nordisk at 1-800-727-6500. A small air bubble may remain at the needle tip, but it will not be injected. Check and make sure that the dose selector is set at 0. H. Turn the dose selector to the number of units you need to inject. The pointer should line up with your dose. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST		STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265			
(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
01910	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the prescription numbers as applicable, medication strength and quantity for one of one discharged resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4's Discharge - Transfer Summary dated January 12, 2024, identified R4 was discharged January 11, 2024, to another facility for a higher level of care. R4's Service Plan (Waiver) dated December 1, 2023, indicated R4 received services including medication assistance six times per day. R4's Current Medications at Discharge form (identified as the form used for the disposition of medications) dated January 11, 2024, identified the medication name, strength, dosing route, dosing instructions, amount remaining, and signature of individuals involved in the disposition. The document indicated medications were sent to the new facility with R4. - The following medications were listed without a prescription number: calcitonin salmon (bone	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST			STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265		
(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
01910	Continued From page 15 health), gabapentin (anticonvulsant), levalbuterol (bronchodilator), Remeron (antidepressant), ropinirole (for restless legs), rosuvastatin (for cholesterol), furosemide (diuretic), ondansetron (for nausea), and promethazine (for nausea); - The following medications were listed without a quantity: estradiol cream (hormone replacement) and acetaminophen (for mild to moderate pain); - The following medications were handwritten at the bottom of the form without a strength: Thermotabs (mineral supplement), Tums (for heartburn), baclofen (muscle relaxant), and benadryl (antihistamine). On April 2, 2024, at 1:48 p.m. registered nurse (RN)-D stated R4's disposition form lacked the required information as noted above. RN-D indicated [The Licensee's] computer software program normally generated the medication name, strength, and prescription number to the form and then the count was completed by nurse completing the disposition. RN-D was not sure why the information was missing. The licensee's 12.39 Medication Disposal policy dated August 1, 2021, noted upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and the names of personnel and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST		STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265			
(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 16	01940			
01940 SS=D	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. 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 one of two	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST			STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265		
(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 17 residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on April 1, 2024, at 1:05 p.m., licensed assisted living director in residence (LALDIR)-A stated the licensee provided treatment management services to their residents, including oxygen. On April 2, 2024, at 9:34 a.m. R2 was observed sitting in her recliner chair in her room wearing oxygen at 2 liters per minute (LPM). R2's diagnoses included chronic obstructive pulmonary disease (COPD) (progressive lung disease with respiratory symptoms and airflow limitations), asthma (airways narrow and swell), emphysema (lung condition causing shortness of breath) bipolar (mental disorder), and paranoid schizophrenia (mental disorder in which people interpret reality abnormally). R2's Service Plan (Waiver) dated January 29, 2024, indicated the resident received medication administration services provided by unlicensed personnel (ULP) eight times daily. The service plan failed to identify the treatment of oxygen administration.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST			STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265		
(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 18 R2's prescriber orders dated February 5, 2023, included an order for continuous Oxygen 2 LPM. R2's medication administration record (MAR) dated April 2024, included staff initials for Oxygen 2 LPM via nasal cannula continuously; needs to remove oxygen prior to smoking. R2's Resident Service Recap dated March 25, 2024, to April 2, 2024, included staff initials each shift for Oxygen maintenance. R2's record included an Individualized Treatment and Therapy Plan dated February 28, 2024, however; the treatment plan lacked the following required content for the use of oxygen: - procedures for notifying a registered nurse when a problem arose with treatments or therapy services. On April 3, 2024, at 11:09 a.m. registered nurse (RN)-D stated R2's record lacked a treatment management plan to include all the required content as noted above. The licensee's 12.07 Treatment & Therapy: Management Plan dated August 1, 2021, noted: 1. Site will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: d. 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			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF PROVIDER OR SUPPLIER HOME FRONT FIRST		STREET ADDRESS, CITY, STATE, ZIP CODE 224 NORTH 19TH STREET MONTEVIDEO, MN 56265			
(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



MN Department of Health
Food, Pools, and Lodging Services
PO Box 64975
St. Paul, MN 55164-0975
218-332-5150

Type: Full
Date: 04/02/24
Time: 15:59:22
Report: 7935241007

Food and Beverage Establishment Inspection Report

Page 1

Location:

Home Front First
224 North 19th Street
Montevideo, MN56265
Chippewa County, 12

Establishment Info:

ID #: 0038448
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3202692930
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

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Chlorine: = 50 ppm at Degrees Fahrenheit
Location: Three Comp Sink
Violation Issued: No

Chlorine: = 50 ppm at Degrees Fahrenheit
Location: Sanitizing Bucket
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: Hoshizaki Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Norlake Cooler
Violation Issued: No

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

Type: Full
Date: 04/02/24
Time: 15:59:22
Report: 7935241007
Home Front First

Food and Beverage Establishment Inspection Report

Page 2

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

I acknowledge receipt of the MN Department of Health inspection report number 7935241007 of 04/02/24.

Certified Food Protection Manager: Elva Salinas

Certification Number: 119354 Expires: 10/19/26

Signed: _____

manager@homefrontmn.com

Signed:  _____

Rebecca Tonneson
Public Health San Supervisor
Fergus Falls District Office
218-332-5142
rebecca.tonneson@state.mn.us