Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONS ON PROVISIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

August 20, 2025

Licensee
Passion Care Homes
2701 9th Avenue East
North Saint Paul, MN 55109

RE: Initial License Number 415335
Health Facility Identification Number (HFID) 40401
Project Number(s) SL40401015

Dear Licensee:

On July 23, 2025, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed April 23, 2025. The follow-up survey found the facility to be in substantial compliance . Based on these findings, the condition(s) on the license were removed effective August 20, 2025.

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

May 23, 2025

Licensee
Passion Care Homes
2701 9th Avenue East
North Saint Paul, MN 55109

RE: Provisional Conditional License Number 415335
Health Facility Identification Number (HFID) 40401
Project Number(s) SL40401015

Dear Licensee:

Please Note: This notice amends the previous notice dated May 22, 2025. Specifically, reference to the number of days of extension is corrected within page 2 and page 3 to accurately and uniformly reflect 45 days. The Notice of Provisional Extension and Conditional License expiration date of July 6, 2025, remains unaltered. No other changes have been made.

The Minnesota Department of Health (MDH) completed a survey on April 23, 2025, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 45-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **July 6, 2025**.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state 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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $3,000.00. **MDH is not imposing these fines against your provisional license at this time.**

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Passion Care Homes a conditional provisional assisted living facility license for 45 calendar days from the date of this notice. At an unannounced point in time, within the 45 calendar

days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Passion Care Homes is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **No new admissions:** Passion Care Homes will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Passion Care Homes must provide the Department:

    i. A list of the names and birthdates of any individuals Passion Care Homes is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents including:
        1. Name and birthdate of each resident
        2. Current payment source for services
        3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

b. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Passion Care Homes to correct the violations cited during the survey as well as to determine the overall practice of Passion Care Homes in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.

c. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD: MDH will determine if Passion Care Homes is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 45-day conditional provisional license period. If MDH determines Passion Care Homes is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Passion Care Homes. If MDH determines Passion Care Homes is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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 Casey DeVries directly at: 651-201-5917.

Sincerely,

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

May 22, 2025

Licensee
Passion Care Homes
2701 9th Avenue East
North Saint Paul, MN 55109

RE: Provisional Conditional License Number 415335
Health Facility Identification Number (HFID) 40401
Project Number(s) SL40401015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 23, 2025, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 45-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **July 6, 2025**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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;
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MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $3,000.00. **MDH is not imposing these fines against your provisional license at this time.**

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Passion Care Homes a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Passion Care Homes is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **No new admissions:** Passion Care Homes will not admit any new residents

under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Passion Care Homes must provide the Department:

i. A list of the names and birthdates of any individuals Passion Care Homes is currently in the process of admitting. These individuals will be able to continue the admittance process.

ii. A list of all current residents including:
    1. Name and birthdate of each resident
    2. Current payment source for services
    3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
    4. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

b. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Passion Care Homes to correct the violations cited during the survey as well as to determine the overall practice of Passion Care Homes in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.

c. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:
MDH will determine if Passion Care Homes is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Passion Care Homes is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Passion Care Homes. If MDH determines Passion Care Homes is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:
Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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 Casey DeVries directly at: 651-201-5917.

Sincerely,

Rick Michals

Rick Michals, J.D.
Executive Regional Operations Manager

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40401	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASSION CARE HOMES	2701 9TH AVENUE EAST NORTH SAINT PAUL, MN 55109

(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: SL40401015-0 On April 21, 2025, through April 23, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two residents; two receiving services under the Provisional Assisted Living Facility license. An immediate correction order was identified on April 21, 2025, issued for SL40401015-0, tag identification 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40401	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASSION CARE HOMES	2701 9TH AVENUE EAST NORTH SAINT PAUL, MN 55109

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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 for determining its staffing level that included an evaluation completed by the clinical nurse supervisor (CNS) at least twice a year (as indicated in Minnesota Administrative Rule 4659.0180). This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40401	A. BUILDING: _____ B. WING _____	04/23/2025

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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 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: On April 21, 2025, at 9:41 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated the licensee's shifts were 7:00 a.m., until 3:00 p.m., 3:00 p.m., until 11:00 p.m., and 11:00 p.m., until 7:00 a.m., and one unlicensed personnel (ULP) worked each shift. On April 21, 2025, at 10:28 a.m., during a facility tour, the surveyor did not observe a staffing plan posted in any location in the facility. In the kitchen area was a bulletin board with a staff schedule. On April 21, 2025, at 2:43 p.m., CNS/LALD-C stated they would look through RTasks (an electronic medical record) for a staffing plan. CNS/LALD-C stated they were unable to find a document a staffing plan. CNS/LALD-C stated they did not have a form that assessed adequate resident staffing level. CNS/LALD-C stated they were unaware the CNS was required to assess resident needs to adequate staffing level and was not aware it had to be evaluated twice a year by the CNS. The licensee's 4.06 Staffing and Scheduling policy dated January 1, 2025, indicated the CNS would develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 470	Continued From page 3 needs 24 hours per day, 7 days a week. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required training content for three	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40401	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 650	Continued From page 4 of three employees (house manager (HM)-B, unlicensed personnel (ULP)-E, ULP-F). 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: HM-B HM-B was hired on August 1, 2024, as house manager and to provide direct care. HM-B's employee record lacked the following required content for competency training: -appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and dressing and assisting with toileting; -standby assistance techniques and how to perform them; -safe transfer techniques and ambulation, and; -range of motioning and positioning. ULP-A ULP-A was hired February 21, 2025, to provide direct care services. ULP-A's employee record lacked the following required content for competency training: -appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing, care of teeth, gums, and	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 650	Continued From page 5 oral prosthetic devices, care and use of hearing aids, and dressing and assisting with toileting; -standby assistance techniques and how to perform them; -safe transfer techniques and ambulation, and; -range of motioning and positioning. ULP-D ULP-D was hired March 14, 2025, to provide direct care services. ULP-D's employee record lacked the following required content for competency training: -appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, and dressing and assisting with toileting; -standby assistance techniques and how to perform them; -safe transfer techniques and ambulation, and; -range of motioning and positioning. On April 22, 2025, at 12:53 p.m. HM-B stated they were unable to remember all the trainings, as the trainings and competencies were completed a while ago. On April 22, 2025, at 2:22 p.m., ULP-A stated they remembered receiving training from the clinical nurse supervisor (CNS) and remembered performing the above-mentioned competencies. On April 22, 2025, at 2:20 p.m., ULP-D stated they remembered receiving training form the CNS. ULP-D stated they completed trainings through an online training program. ULP-D stated they remember performing the above-mentioned competencies in the presence of the CNS.	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 650	Continued From page 6 On April 23, 2025, at 11:15 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were responsible for the training and competency of staff. CNS/LALD-C stated the process was staff were shown how to perform the competency, then observed if they were competent at performing the skills. CNS/LALD-C stated they were unaware they had to document staff were observed as competent in the above areas. The licensee's 5.02 Competency Training Evaluations policy dated November 1, 2022, indicated staff performing delegated tasks must demonstrate they were competency before being allowed to perform the delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current 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.	0 660		

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0 660	Continued From page 7 (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to 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 baseline screening prior to working with residents for three of three employees (house manager (HM)-B, unlicensed personnel (ULP)-A, 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) 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: HM-B HM-B was hired on August 1, 2024, as a house manager and to provide direct care. HM-B's employee record contained a baseline TB screening dated October 15, 2024. The form was completed 75 days after HM-B's hire date. ULP-A ULP-A was hired February 21, 2025, to provide direct care services. ULP-A's employee record contained a baseline TB screening dated February 27, 2025. The form	0 660		

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0 660	Continued From page 8 was completed six days after ULP-A's hire date. ULP-D ULP-D was hired March 14, 2025, to provide direct care services. ULP-D's employee record contained a baseline TB screening dated March 25, 2025. The TB screening was completed 11 days after ULP-D was hired. On April 23, 2025, at 11:11 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were responsible for the TB screenings. CNS/LALD-C stated they were unaware the screenings were required to be completed on or before the date of hire. The licensee's 8.16 Tuberculosis Screening policy dated January 1, 2025, indicated licensee's TB infection control program would follow guidelines from the CDC. The CDC Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated May 17, 2019, recommended all United States health care personnel should have a completed a TB risk assessment, symptom evaluation, TB testing for tuberculosis, with additional working for TB disease with a positive test results or symptoms compatible with TB disease. The Minnesota Department of Health Tuberculosis Prevention and Control Program dated July 2013 recommended a TB screening was required for all healthcare workers at date of hire, which consisted of assessment for current symptoms of active TB disease, and assessing TB history.	0 660		

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0 660	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness (EP) plan with all the required	0 680		

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0 680	Continued From page 10 content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EP plan dated April 25, 2025, lacked evidence of the following required content: - process for collaboration with local, tribal, regional and State and Federal EP to maintain integrated response; - roles under a waiver declared by secretary; - communication plan to include all the following names/contact information: staff, entities providing services under agreement, resident physicians, other facilities, and volunteers; - emergency preparation training program; - emergency preparation and testing, and; - emergency preparation testing requirements. On April 23, 2025, at 11:11 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were responsible for the EP plan. CNS/LALD-C stated there was a lot of information to include, and the survey process will be a learning curve. The licensee's 9.01 Emergency Preparedness Plan Appendix Z Compliance dated January 1, 2025, indicated the licensee would have an effective and compliant EP plan and would align	0 680		

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0 680	Continued From page 11 with the Center for Medicare and Medicaid Services State operational manual appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=E	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; (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	0 810		

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0 810	Continued From page 12 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 record review and interview, the licensee failed to develop the fire safety and evacuation plan with required content and maintain all parts of the plan as readily available. This had the potential to directly affect two residents and all 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). The findings include: On April 23, 2025, clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP failed to include fire safety and evacuation instructions for residents evident by no actions in the plan. During an interview on April 23, 2025, at 1:45 p.m., CNS/LALD-C verified these instructions had not been developed.	0 810		

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0 810	Continued From page 13 The FSEP failed to include evacuation procedures for the individualized unique needs of one resident evident by no procedures in the plan. Two residents had been identified as requiring staff assistance in the event of an evacuation. Evacuation procedures were listed for one resident. During an interview on April 23, 2025, at 1:45 p.m., CNS/LALD-C verified these procedures were lacking. The licensee failed to maintain all parts of the FSEP as readily available for staff accessibility evident by a record review of the printed paper copy of the FSEP. Record review indicated the printed paper copy of the FSEP did not include the identified evacuation procedures for the individualized unique needs of residents. During an interview on April 23, 2025, at 1:45 p.m., CNS/LALD-C stated residents requiring staff assistance in an emergency had been identified and these procedures were maintained electronically on the computer. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01750 SS=F	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	01750		

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01750	Continued From page 14 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 the registered nurse (RN) specified in writing, specific instructions for medication administration for one of two 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 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: R2 admitted to the facility on February 18, 2025, and began receiving assisted living services. R2's Addendum to Contract - Waiver dated February 19, 2025, indicated R2 received the following services: medication administration. R2's medication administration record (MAR) dated April 1, 2025, through April 31, 2025, indicated R2 received the medication lidocaine patch. R2's record contained an electronically signed order dated March 21, 2025, for the lidocaine patch. The order lacked direction for where the lidocaine patch should be placed.	01750		

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01750	Continued From page 15 R2's record lacked instructions for staff to know where to apply the lidocaine patch. On April 22, 2025, at 2:54 p.m., the surveyor inquired if there were parameters or instructions for the lidocaine patch. The surveyor observed HM-B look through RTasks (web-based electronic health record (EHR) platform). HM-B stated there were no parameters or placement instructions. On April 23, 2025, at 11:14 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated the order from the prescriber did not contain placement instructions for the patch. CNS/LALD-C stated R2 was alert and mentally competent and was able to tell staff where to place the patch. CNS/LALD-C stated they were unaware they were required to instruct staff where to place the patch. The licensee's 7.15 Medication and Treatment - Administration and delegation policy Dated January 1, 2025, indicated the registered nurse would staff in the proper methods with respect to each resident to administer medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure to permit only authorized personnel to have access to medications for two of two residents (R1, 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 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: REFRIGERATED MEDICATIONS On April 21, 2025, at 10:28 a.m., in the basement of the two-level assisted living facility (ALF), the surveyor observed a small refrigerator. In the refrigerator were 25 unopened Lantus insulin injection pens for R1, eight unopened Humalog insulin injection pens for R1, and 15 unopened Trulicity injection pens for R1. On the main level in the kitchen refrigerator were 17 unopened Lantus insulin injection pens for R1, five unopened Humalog insulin injection pens for R1, and four unopened Bydueron BCise injection pens for R2. Both refrigerators lacked a locking mechanism and were unsecured. On April 21, 2025, at 10:28 a.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated the refrigerators did not have a locking mechanism. CNS/LALD-C stated the medications should be secured to only allow	01880		

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01880	Continued From page 17 staff to access them. CNS/LALD-C stated they would have to figure out how to lock the medications. MEDICATIONS LEFT UNSECURED DURING MEDICATION ADMINISTRATION On April 22, 2025, at 8:06 a.m., on the main level of the ALF which consisted of a common area that contained a medication cart, and a kitchen and dining area, the surveyor observed house manager (HM)-B at the medication cart preparing medications for R1. R1 was seated on a sofa in the common area near the medication cart. HM-B placed several oral medications into a medication cup. HM-B measured the medication polyethylene powder and poured into a cup of water and mixed it with a spoon. HM-B placed the oral medications into the medication cart and locked the medication cart. With R1 on the sofa, and with no other staff present, HM-B walked down to the basement. The polyethylene powder medication was unsecured. On April 22, 2025, at 8:57 a.m., HM-B stated they were trained to secure the medications by ensuring the medication cart was always locked. HM-B stated they thought they placed the polyethylene powder into the medication cart. HM-B stated that was an oversight for not securing the polyethylene powder. On April 22, 2025, at 9:01 a.m., CNS/LALD-C stated staff were trained to always have medications within eye view and to lock the medication cart. CNS/LALD-C stated HM-B should have secured all the medications and that situation should not have occurred. The licensee's 7.11 Medication Storage policy dated January 1, 2025, indicated medications will	01880		

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01880	Continued From page 18 be kept securely locked and stored per manufactures directions. Only authorized staff will have access to stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the license failed to provide care and services according to acceptable health care, medical, or nursing standards for one of two residents (R2) that had consumer bedrails. Additionally, licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of two residents (R1) that had hospital bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	02310		

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02310	Continued From page 19 The findings include: R2 R2 was admitted to the facility on February 18, 2025, and began receiving assisted living services. R2's Addendum to Contract - Waiver dated February 19, 2025, indicated R2 received the following services: ambulation assistance, bathing assistance, dressing, housekeeping, behavior management, meal assistance and reminder, medication administration, glucose check, garbage removal, safety check, and toileting. R2's diagnoses included type 2 diabetes (a condition where the body cannot regular blood sugars), atherosclerotic heart disease (a buildup of fat and other substances in and on the artery walls), major depressive disorder, dyspnea (difficulty breathing), hypothyroidism (an underactive gland that doesn't provide enough hormones to help the body function), and malignant neoplasm of the thyroid gland (abnormal growth of the gland). On April 21, 2025, at 12:15 p.m., in R2's room, the surveyor observed bilateral consumer bed rails. There was no identifying make, model, or serial numbers on the bed rails. The bed rails consisted of an upside down "U" shape with two poles resting on the floor. There was a single bar that connected both bed rails which ran under the mattress. The bed rail was firmly attached. The bed rail measured 29 inches (") in total length. The height of the bed rail was 23". There were two sections. The first section measured 29" in length with a height of four inches. The second	02310		

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02310	Continued From page 20 section which was directly underneath measured 22" in length with a height of five inches. R2's record included a Bed Rail Assessment dated February 19, 2025, which indicated R2 had bilateral side rails. R2's record lacked: - condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - installation and use of the bed rail according to manufacturer's guidelines, and; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation. R1 R1 was admitted to the facility on March 17, 2025, and began receiving assisted living services. R1's Addendum to Contract - Wavier dated March 17, 2025, indicated R1 received the following services: ambulation assistance, bathing assistance, bedmaking, dressing, grooming, housekeeping, behavior management, meal reminder, glucose check, vital sign recording, garbage removal safety check, and toileting. R1's diagnoses included type 2 diabetes, chronic kidney disease, Parkinson's disease (a disorder that affects movement, causing tremors, slow movement, and rigidity), unspecified dementia without behavioral disturbance, hypocalcemia (low calcium), muscle weakness, neuralgia (nerve pain), hyperlipidemia (high cholesterol), and obstruction sleep apnea (a disorder where breathing stops and starts during sleep).	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40401	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASSION CARE HOMES	2701 9TH AVENUE EAST NORTH SAINT PAUL, MN 55109

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02310	Continued From page 21 On April 21, 2025, at 10:40 a.m., in R1's room, the surveyor observed a single hospital bed rail attached to a hospital bed. The identifying marks were "Drive 1382208041618". There were three sections. Starting from the left side of the bed rail, there were two areas that measured four inches length with a height of 13". The next section was five areas that measured three inches length with a height of 18". The next three areas that measured four inches length with a height of 13". R1's record included a Bed Safety Assessment dated March 31, 2025, which indicated R1 had a side rail. R1's medical record lacked: - measurements of bed rail entrapment zones. On April 21, 2025, at 12:38 p.m., and 2:11 p.m., clinical nurse supervisor/licensed assisted living director (CNS/LALD)-C stated they were responsible for the bed rail assessments. CNS/LALD-C stated they were aware the bed rail was required to be installed according to manufacturer's instructions. CNS/LALD-C stated they attempted to find installation instructions online for R2's bed rail, but were unable to find them. CNS/LALD-C stated they did not use specific manufacturer's instructions to install the bed rails. CNS/LALD-C stated when R2 was admitted, the other assisted living facility (ALF) did not send manufacturer's instructions for the bed rails. CNS/LALD-C stated they did assess the bed rail for stability and condition but did not document that information in R2's medical record. CNS/LALD-C stated they measured the bed rails zones for R1 to ensure they were within the recommended dimensional zones but did not document the zones in R1's medical record. CNS/LALD-C stated they were unaware they	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40401	A. BUILDING: _____ B. WING _____	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 22 were required to measure and document the measurements of the zones. CNS/LALD-C stated a charting standard was, it if was not documented, it was not done. The licensee's 6.28 Side Rail policy dated November 1, 2022, indicated the licensee would verify the side rail is in use is of safe design and will be utilized consistent with the manufacturer's instruction. Additionally, the licensee will follow Food, Drug Administrations recommended dimensional measurements to reduce entrapment. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (within the rail) should not exceed 4 and 3/4 inches, zone 2 (under the rail, between rail supports or next to a single rail support) should not exceed 4 and 3/4 inches, zone 3 (between the rail and the mattress), should not exceed 4 and 3/4 inches, and zone 4 (under the rail, at the ends of the rail) should not exceed 2 and 3/8 inches or be greater than a 60 degree angle. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40401	A. BUILDING: _____ B. WING _____	04/23/2025

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02310	Continued From page 23 being an improper restraint." Also included, documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

Minnesota Department of Health
Food Pools & Lodging Services
P.O. Box 64974
St Paul, MN 55164-0975
651 201 4500

Type: Full
Date: *04/21/25*
Time: 09:29:42
Report: 8058251097

Food and Beverage Establishment Inspection Report

Location:
PASSION CARE HOMES
2701 9TH AVENUE EAST NORTH
St Paul, MN55109
Ramsey County, 62

Establishment Info:
ID #: 0044109
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/25

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = --- at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MANGO
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTOR KEITH LANGLEY

RESIDENTIAL HOME WITH NON COMMERCIAL APPLIANCES AND FINISHES

Type: Full
Date: *04/21/25*
Time: 09:29:42
Report: 8058251097
PASSION CARE HOMES

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 8058251097 of 04/21/25.

Certified Food Protection Manager: PA YANG

Certification Number: 11536 Expires: 02/09/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
PA YANG
PIC

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
aaron.gertz@state.mn.us