Electronically Delivered

July 9, 2024

Licensee
Bridges Health LLC
7515 12th Avenue South
Richfield, MN 55423

RE: Project Number(s) SL37078015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 18, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37078	A. BUILDING: _____ B. WING _____	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES HEALTH LLC	7515 12TH AVENUE SOUTH RICHFIELD, MN 55423

(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: SL37078015 On June 17, 2024, through June 18, 2024, the Minnesota Department of Health conducted an initial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents, three 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 Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record (DOR) for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 17, 2024, at 10:15 a.m., during the entrance conference, the surveyor reviewed the Board of Executives for Long-term Services and Supports (BELTSS) website with LALD-A. LALD-A's license was current but lacked identification as the DOR for the licensee. Also, LALD-A stated she was not aware of the assisted living license requirement to be identified as DOR for the licensee in the BELTSS website for the licensee. On June 18, 2024, at 1:00 p.m., during the exit conference, the surveyor checked the BELTSS website and LALD-A remained unlisted as the	0 110		

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0 110	Continued From page 2 DOR for the licensee. LALD-A stated she should have identified herself as the DOR for licensee. In addition, LALD-A verbalized she planned to update the DOR in the BELTSS website. The licensee's Personnel Records policy dated August 1, 2021, included "2. At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements: Evidence of current professional licensure, registration or certification." No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing	0 510		

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0 510	Continued From page 3 standards for infection control for one of one resident (R2) observed with treatment self-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: On June 18, 2024, at 8:12 a.m., the surveyor observed the licensed assisted living director (LALD)-A witness R2 perform self-blood glucose (BG) testing using R2's personal use glucometer. First, LALD-A completed hand hygiene, donned (applied) gloves, and obtained R2's blood glucose testing supplies from the locked medication storage closet. Next, LALD-A and R2 sat down at the dining room table to complete blood glucose testing. R2 completed self BG testing, R2 wiped her left-hand forefinger with an alcohol prep, used automatic lancet, drop of blood on glucose test strip and obtained her BG test result. Next LALD-A verified R2's BG test result and entered R2's BG test result in the electronic medical record. R2 failed to perform hand hygiene while completing self BG testing. Next, LALD-A doffed (removed) gloves, completed hand hygiene, and R2 left the dining room and went into the main living area of the facility through the sliding glass doors outside to the shared patio area without completing hand hygiene. Finally, LALD-A did not ask or offer R2 to complete hand hygiene prior to or after self-blood glucose testing.	0 510		

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0 510	Continued From page 4 On June 18, 2024, at 8:12 a.m., LALD-A stated she should have asked R2 to complete hand hygiene before R2's self-blood glucose testing. Also, LALD-A verbalized R2's mental health disorder made it challenging for the employees to ask R2 to perform certain tasks, but the LALD-A planned to offer and encourage R2 to complete hand hygiene whenever R2 performed self-blood glucose testing. Additionally, LALD-A stated she also planned to educate her employees. On June 18, 2024, at 11:22 a.m., clinical nurse supervisor (CNS)-B verbalized R2 should have completed hand hygiene before and after R2 performed self BG testing. The CDC's document titled Considerations for Blood Glucose Monitoring and Insulin administration dated March 18, 2024, included "Blood glucose monitoring guides therapy for persons with diabetes. Blood glucose monitoring and insulin administration can happen in two ways: -Self-monitoring and administration, where the individual performs all steps of the testing and insulin administration themselves; and -Assisted monitoring and administration, where another person assists with or performs testing and insulin administration for an individual." Furthermore, included under section "Hand hygiene: -Wear gloves during blood glucose monitoring and during any other procedure that involves potential exposure to blood or body fluids; -Change gloves between patient contacts. Change gloves that have touched potentially blood-contaminated objects or fingerstick wounds before touching clean surfaces. Discard gloves in appropriate receptacles (containers); and	0 510		

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0 510	Continued From page 5 -Perform hand hygiene immediately after removing gloves and before touching other medical supplies intended for use on other persons." The licensee's Infection Control policy dated August 1, 2021, in the last section titled Handwashing included, "1. All persons may be carriers of disease-producing microorganisms and therefore a possible source of infection." Also, indicated "3. Hands should be washed at the following times: -before and after treatments." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year	0 810		

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0 810	Continued From page 6 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, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on	0 810		

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0 810	Continued From page 7 June 18, 2024, at 10:05 a.m. with licensed assisted living director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the FSEP (fire safety evacuation plan) included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (rescue, alarm, confine, extinguish and evacuate). Also, the FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The policy reviewed was a generic policy from another resource. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
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	01940		

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01940	Continued From page 8 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 an individual treatment or therapy management plan (ITTMP) to include all required content for one of one resident (R2) who received treatments. 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 June 18, 2024, at 8:12 a.m., the surveyor	01940		

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01940	Continued From page 9 observed licensed assisted living director (LALD)-A complete medication administration and treatment management for R2. R2 was admitted to the licensee on September 18, 2023. R2's diagnoses included schizoaffective disorder (a mental health disorder), bipolar disorder (a mental health condition that causes extreme mood swings), post-traumatic stress disorder (a mental health condition that's triggered by either experiencing or witnessing a traumatic event), and non-insulin dependent diabetes mellitus (NIDDM). R2's signed "Service Plan (Waiver) - Addendum to Contract" dated June 17, 2024, indicated R2 received the following services, personal cares, laundry, meals, behavior management, medication administration, and blood glucose testing three times per day. R2's provider orders signed and dated January 2, 2024, ordered R2's blood glucose testing four times per day. R2's Service Recap Summary dated June 1, 2024, through June 17, 2024, indicated R2 received assistance with recording R2's blood glucose testing daily at 7:00 a.m., 12:00 p.m., and 5:00 p.m. R2's medical record included a document titled "Vital Signs/Blood Glucose" dated May 18, 2024, through June 17, 2024, which included R2's blood glucose testing results. R2's medical record lacked an ITTMP to include the following content:	01940		

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01940	Continued From page 10 -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -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. On June 18, 2024, at 11:48 a.m., clinical nurse supervisor (CNS)-B stated she knew what the surveyor meant about an individualized treatment management plan. Also, CNS-B stated she was unable to locate a treatment management plan for R2 and she had not completed a treatment plan for R2. The licensee's Treatment and Therapy Management policy dated August 1, 2021, included "6. The RN or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: a. Type of service to be provided; b. Procedures for documenting treatments or therapies; c. Procedures for monitoring treatments or	01940		

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01940	Continued From page 11 therapies to prevent possible complications or adverse reactions; d. Identification of treatment or therapy tasks delegated to unlicensed personnel; and e. Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to accurately transcribe provider's orders that were provided for one of one resident (R2) receiving treatments. 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	01960		

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01960	Continued From page 12 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 June 18, 2024, at 8:12 a.m., the surveyor observed licensed assisted living director (LALD)-A complete medication administration and treatment management for R2. R2 was admitted to the licensee on September 18, 2023. R2's diagnoses included schizoaffective disorder (a mental health disorder), bipolar disorder (a mental health condition that causes extreme mood swings), post-traumatic stress disorder (a mental health condition that's triggered by either experiencing or witnessing a traumatic event), and non-insulin dependent diabetes mellitus (NIDDM). R2's signed Service Plan (Waiver) - Addendum to Contract dated June 17, 2024, indicated R2 received the following services: personal cares, laundry, meals, behavior management, medication administration, and blood glucose testing three times per day. R2's Service Recap Summary dated June 1, 2024, through June 17, 2024, indicated R2 received assistance with blood glucose testing daily at 7:00 a.m., 12:00 p.m., and 5:00 p.m. R2's signed provider orders dated January 2, 2024, for blood glucose testing included the following:	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37078	A. BUILDING: _____ B. WING _____	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIDGES HEALTH LLC	7515 12TH AVENUE SOUTH RICHFIELD, MN 55423

(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
01960	Continued From page 13 -glucose blood (accu-chek guide) test strips, use to test four times a day; -Accu-Chek Softclix lancets, use to test four times a day; -Freestyle Libre 2, use to monitor blood glucose levels; and -Freestyle Libre 2, use one sensor every 14 days. R2's medical record included a report titled "Vital Signs/Blood Glucose" dated May 18, 2024, through June 17, 2024, which included R2's blood glucose (BG) test results completed. On June 18, 2024, at 11:48 a.m., clinical nurse supervisor (CNS)-B stated she missed the updated blood glucose testing order from R2's provider on January 2, 2024, changing BG testing from three times daily to four times daily and needed to clarify R2's BG testing orders with the provider. Also, CNS-B verbalized she planned to follow up on the BG testing order with R2's provider. On June 18, 2024, at 12:30 p.m., CNS-B verbalized to R2 her provider ordered blood glucose testing four times daily. The licensee's Treatment and Therapy Management policy dated August 1, 2021, included "2. The RN or licensed health professional will obtain orders or prescriptions for all treatments and therapies. The order will include the following elements: a. Resident Name; b. Description of the treatment or therapy to be provided; c. Frequency; and d. Other pertinent information. No further information provided.	01960		

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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01960	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01960		

Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *06/17/24*
Time: 10:30:58
Report: 1050241117

Food and Beverage Establishment Inspection Report

Location:
Bridges Health Llc
7515 12th Avenue South
Richfield, MN55423
Hennepin County, 27

Establishment Info:
ID #: 0038093
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6126364562
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 182F Degrees Fahrenheit
Location: Whirpool Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/Milk
Temperature: 39F Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

Inspection was completed by MDH Andrew Spaulding, Fatima and John Mitchell Manager. Dede Hinnendael was the lead Health Regulation Division Nurse Evaluator. Facility has three residents on site at time of inspection.
Meals are prepared on site. This establishment has a residential kitchen. The kitchen has wood cabinets with a hollow base and tile flooring. All found to be in good condition.

No cooked meals are kept inside of refrigerator. No leftovers are kept after meals are cooked. Utensils are plastic and thrown out after use.

QAC test strips are currently in use with dishwasher verified expiration date.

Discussed the following:
-Thermometer calibration
-Employee illness policy and logging requirements
-Handwashing

-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

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 1050241117 of 06/17/24.

Certified Food Protection Manager: FATIMA MUSSE

Certification Number: FM110569 Expires: 12/11/24

Inspection report reviewed with person in charge and emailed.

Signed:_____

FATIMA MUSSE
OPERATOR

Signed:_____

Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us