Electronically Delivered

May 2, 2023

Licensee
Unity Place
2611 Central Avenue Northeast
Minneapolis, MN 55418

RE: Project Number(s) SL25496015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 12, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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 and enforcement actions 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 the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25496	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY PLACE	2611 CENTRAL AVENUE NE MINNEAPOLIS, MN 55418

(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: SL25496015 On April 10, 2023, through April 12, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 36 active residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current	0 660		

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0 660	Continued From page 1 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the license failed to maintain a tuberculosis (TB) infection control program based on guidelines by the Center for Disease Control (CDC) and Minnesota Department of Health and ensure TB health screening was completed for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's facility TB risk assessment, dated June 10, 2022, indicated low risk.	0 660		

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0 660	Continued From page 2 ULP-E was hired October, 11, 2021, and provided medication management services to licensee residents. On April 11, 2023, from 8:15 a.m., through 9:35 a.m., the evaluator observed ULP-E administer medications to licensee residents. ULP-E's employee record included a negative TB Gold blood test, dated October 6, 2021, but lacked evidence of a TB history and symptom screen. On April 12, 2023, at 10:00 a.m., licensed assisted living director (LALD)-A acknowledged ULP-E's employee record lacked evidence of the TB history and symptom screening. LALD-A stated the licensee would develop and ensure the history and symptom screening was completed for each employee. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA(serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 800	Continued From page 3	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition 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: On a facility tour on April 11, 2023, from approximately 10:30 a.m. to 12:30 p.m. with the property manager (PM)-G it was observed that multiple window screens throughout the facility	0 800		

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0 800	Continued From page 4 had large holes and tears along the edges of the screen frames. PM-G stated that the screens had been damaged at the end of summer 2022 when they had the building power-washed and painted. Any operable windows that have a screen installed must maintain the screen in good repair without any tears or punctures. It was also observed in storage room 302 that the access panel to the plenum space above the ceiling was missing its cover. Plumbing elements and structural elements for the floor above could be seen through the opening. PM-G verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800		
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	0 810		

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0 810	Continued From page 5 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 the required elements, and failed to provide required employee and resident training on fire safety and evacuation. 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:	0 810		

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0 810	Continued From page 6 A record review and interview were conducted on April 11, 2023, at approximately 12:30 p.m. with the senior director (SD)-B and the property manager (PM)-G on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. During interview, SD-B and PM-G verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, SD-B and PM-G verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility did have residents identified that needed assistance in evacuation, but did not include what type of assistance or procedures for evacuation. During interview, SD-B and PM-G verified that the fire safety and evacuation plan for the facility lacked these provisions.	0 810		

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0 810	Continued From page 7 Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. The policy indicated that employees were trained upon hire and then annually after that. Employee training was completed through an online third party and did not include the specific policy and procedures for the facility. During interview, SD-B and PM-G verified that the training policy for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have a policy on annual training for residents who can assist in their own evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During interview, SD-B and PM-G stated that the facility did not have documentation or a policy on offering resident training on the fire safety and evacuation plan and that training for residents was to participate in the scheduled fire drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 970 SS=F	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970		

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0 970	Continued From page 8 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all 36 residents living within the assisted living facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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 Customized Living Contract included a liability clause which indicated the "landlord is not liable to Tenant or Tenant's guests for any injury, death or property damage occurring in the Apartment or on the Landlord's premises unless such injury, death or property damage occurs as the result of Landlord's own negligent acts. By way of example and without limitation, Landlord is not liable for any injury, death or damage occurring as the result of Tenant's receipt of health-related, supportive or other services from third party providers." On April 12, 2023, at 10:00 a.m., LALD-A acknowledged the licensee's assisted living contract included a waiver of liability, and the waiver would need to be removed or modified.	0 970		

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0 970	Continued From page 9 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01440 SS=F	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 performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing or therapy tasks	01440		

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01440	Continued From page 10	01440		

within 30 days of first providing those services for two of two employees (unlicensed personnel (ULP)-E and ULP-F) with employee records reviewed.

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:

ULP-E was hired to provide assisted living services on October 11, 2021.

ULP-F was hired to provide assisted living services on June 28, 2021.

ULP-E and ULP-F's employee records lacked documentation that ULP-E and ULP-F had been supervised performing delegated tasks.

On April 12, 2023, at 10:00 a.m., licensed assisted living director (LALD)-A and senior director (SD)-B acknowledged ULP-E and ULP-F had not been supervised performing delegated tasks within 30 days of hire. LALD-A stated the licensee ULP's are supervised following training to ensure competent, but the licensee did not perform additional supervision within 30 days of hire.

The licensee's undated Supervision of Unlicensed Personnel policy directed that direct supervision of staff performing delegated tasks

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01440	Continued From page 11 must be provided within 14 days after the date on which the individual begins working for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	01620		

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01620	Continued From page 12 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment no more than 14 days after the initiation of services for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1 was admitted on June 1, 2021, and had diagnoses including Bipolar disorder. R1's service plan, dated January 8, 2023, indicated services which included medication administration. R1's record included an initial assessment on June 1, 2021, a 14-day assessment completed on June 17, 2021, and assessments completed on October 8, 2022 and February 10, 2023. No additional 90 day or change of condition assessments were completed or included in R1's record. On April 12, 2023, at 10:00 a.m., licensed assisted living director (LALD)-A and senior director (SD)-B confirmed they were not able to locate additional assessments for R1, and were unsure why the assessments were not included in the resident record.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25496	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY PLACE	2611 CENTRAL AVENUE NE MINNEAPOLIS, MN 55418

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01620	Continued From page 13 The licensee's undated "Nursing Assessment Process policy verified nursing "reassessments are required to be completed on needed based on changes in the needs of the client and cannot exceed 90 days." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on observation interview and record review, the licensee failed to ensure the unlicensed personnel were following the policies and procedures for giving accurate and current medications for those residents who received medication management services during planned times away from home for one of one clients (R3).	01780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25496	A. BUILDING: _____ B. WING _____	04/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITY PLACE	2611 CENTRAL AVENUE NE MINNEAPOLIS, MN 55418

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01780	Continued From page 14	01780		

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:

R3 had diagnoses including Schizoaffective disorder, and services to include medication administration.

On April 11, 2023, at 9:50 a.m., R3 entered the licensee's office and stated she was leaving for her job and needed her medications. Unlicensed personnel (ULP)-E handed R3 a prepackaged envelope of medications. The envelope lacked documentation of the date, medication name, number of tablets, and the initials of the person who packaged the medications. ULP-E stated he or the RN will set up medications for R3 daily, and has offered to send the medication record (MAR) with R3, but she refuses to take the MAR.

On April 12, 2023, at 10:00 a.m., licensed assisted living director (LALD)-A and senior director (SD)-B verified the ULP's are trained on medication setup for clients who are away from home. The ULP's will daily set up medications for clients who go to work or leave the facility for the day. The ULP's are trained to include the required information on the envelope and send the MAR with the client. SD-B stated R3 will refuse to take the MAR, as she receives the medications daily.

The licensee's undated Medication Packaging Process policy indicated "all scheduled pill form

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25496	A. BUILDING: _____ B. WING _____	04/12/2023

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01780	Continued From page 15 medications should be placed into one envelope or pill box window, per med pass (i.e. all AM medication for one med pass should go into one envelope vs. each medication being packed separately)." The policy indicated the envelope should include "the client name, the Date that the medication should be taken, The Time of the day that the medication should be taken (AM, Noon, Evening, HS [hour of sleep], the # [number] of tabs, and the initials of the person packaging the medication." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01780		

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

Type: Full
Date: *04/11/23*
Time: 12:50:00
Report: 1013231096

Food and Beverage Establishment Inspection Report

Location:
Unity Place
2611 Central Avenue Ne
Minneapolis, MN55418
Hennepin County, 27

Establishment Info:
ID #: 0038529
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6127880833
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.

Food and Equipment Temperatures

Process/Item: Milk
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator Jolene B.

Food is prepared at the company's production kitchen in Vadnais Heights. Food is delivered hot and portioned. Each unit has a kitchen that the resident can use. No food is prepared or handled on-site by staff. No ware is washed at the facility. Limited TCS food is held in the facility's refrigerator (milk).

Discussed ware washing, receiving temperatures, temperature control, final cook temperatures, and food handling procedures.

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 1013231096 of 04/11/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Jake Frahm
Operator

Signed: JM
Jerry Malloy
Public Health Sanitarian
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us