DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 29, 2024

Licensee
Prosper Home Health & Transportation Services LLC
10025 Colfax Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL36295015

Dear Licensee:

On October 9, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 19, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

HHH

Electronically Delivered

August 23, 2024

Licensee
Prosper Home Health & Transport
10025 Colfax Avenue South
Bloomington, MN 55431

RE: Project Number(s) SL36295015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 19, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36295	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROSPER HOME HEALTH & TRANSPOR	10025 COLFAX AVENUE SOUTH BLOOMINGTON, MN 55431

(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: SL36295015-0 On July 15, 2024, through July 19, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four resident(s); four receiving services under the provider's Assisted Living Facility 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.	
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must	0 650		

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0 650	Continued From page 1 include the following information: (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 documentation of annual performance reviews that identified areas of improvement and training needs for one of two employees (unlicensed personnel (ULP)-B). 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).	0 650		

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0 650	Continued From page 2 The findings include: ULP-B had a hire date of January 27, 2022, and provided direct care services to residents. ULP-B's employee record lacked a performance review for 2023, to identify areas of improvement and training needs. On July 16, 2024, at 11:00 a.m., registered nurse (RN)-A stated she completes employee performance reviews annually. RN-A stated all performance reviews should be present in the employee records, and was unsure why ULP-B's was not completed, as required. The licensee's Employee Evaluation policy, dated August 1, 2021, verified all licensee staff will be given an employee evaluation at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 790 SS=D	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During facility tour on July 18, 2024, from 10:25 a.m. through 11:15 a.m., with registered nurse (RN)-A the surveyor observed that the portable fire extinguishers located in the main floor activity room and basement laundry room lacked records to show the required monthly visual inspections were performed. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly. During interview on July 18, 2024, at 11:15 a.m., survey staff explained to RN-A that the portable fire extinguishers must be provided with monthly visual inspection or "quick checks" of each extinguisher by their employees to ensure all portable extinguishers are readily available, fully charged, and operable at their designated	0 790		

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0 790	Continued From page 4 location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. RN-A stated that they understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	0 800		

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0 800	Continued From page 5 The findings include: During facility tour on July 18, 2024, from 10:25 a.m. through 11:15 a.m., with registered nurse (RN)-A, the surveyor made the following observations: -An electrical outlet in a storage area in the basement laundry room was not mounted to the wall and was hanging from the electrical wires that served the outlet. Loose outlets and wiring can be a fire hazard and should be secured in place. -The posted evacuation floor plan did not have accurate rooms identified for the basement. There was a bedroom labeled on the plan that RN-A stated was being used for an office. Survey staff explained that the plan would need to be updated if that room was not intended for a resident sleeping room. -The posted evacuation floor plan showed an emergency exit at the door leading from the dwelling into the attached garage. Emergency exits cannot lead into a higher hazard area, and there was no walk door leading from the garage to the exterior. -The overhead door from the activity room into the attached garage was marked with an exit sign. Marked exit doors shall not lead into a higher hazard area, and overhead doors cannot be used as an emergency exit. RN-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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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 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 interview and record review, the	0 810		

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0 810	Continued From page 7 licensee failed to develop a fire safety and evacuation plan with required content and failed to conduct the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 18, 2024, at 11:20 a.m., registered nurse (RN)-A 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 licensee FSEP titled "Fire Safety", dated August 1, 2021, lacked the following: The FSEP included standard employee procedures, but lacked 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, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as manual fire alarms. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not	0 810		

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0 810	Continued From page 8 have life safety systems stated in the policy. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include unique needs/ evacuation status for each individual resident in writing and readily available for use in the event of a fire or similar emergency. 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. During an interview on July 18, 2024, at 11:40 a.m., RN-A stated they understood the areas of the plan that needed to be updated. TRAINING Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. RN-A stated that employees were trained annually and provided documentation showing training. Training on the fire safety and evacuation plan is required for staff at hire and at least twice annually thereafter. Survey staff showed RN-A where the requirement was stated in their policy. Record review indicated the licensee failed to provide evacuation training to residents at least once per year. RN-A was unable to provide documentation showing any training offered or training scheduled for a future date for residents	0 810		

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0 810	Continued From page 9 on the fire safety and evacuation plan. RN-A stated that residents participate in fire drills, and they thought this met the requirement. Survey staff explained the requirements for offering training to residents on the FSEP and evacuation procedures, and that training is a separate requirement. During an interview on July 18, 2024, at 11:40 a.m., RN-A stated they understood the requirement for staff and resident training. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect a limited number of residents and staff.	0 820		

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0 820	Continued From page 10 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: During facility tour on July 18, 2024, from 10:25 a.m. through 11:15 a.m., with registered nurse (RN)-A, the surveyor observed that the door leading from the facility into the attached garage had a slide lock on the facility side of the door in addition to the doorknob and deadbolt lock. The slide lock could not be used from the garage side of the door and there were no other exits leading out of the garage. Staff or residents would not be able to exit the garage if the slide lock was engaged while they were inside the garage. RN-A visually verified the deficient condition while accompanying on the tour and stated they would remove the slide lock from the door. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual	01500		

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01500	Continued From page 11 training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication;	01500		

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PROSPER HOME HEALTH & TRANSPOR	10025 COLFAX AVENUE SOUTH BLOOMINGTON, MN 55431

(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
01500	Continued From page 12 (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained documentation of eight hours of annual training for one of two employees (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B had a hire date of January 27, 2022, and provided direct care services to residents. ULP-B's employee record lacked documentation of eight hours of annual training completed within the last 12 months, including the following required topics: -training on reporting of maltreatment of vulnerable adults under section 626.557;	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36295	A. BUILDING: _____ B. WING _____	07/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROSPER HOME HEALTH & TRANSPOR	10025 COLFAX AVENUE SOUTH BLOOMINGTON, MN 55431

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01500	Continued From page 13 -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the licensee's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On July 16, 2024, at 11:00 a.m., registered nurse (RN)-A stated she did not complete the required annual training for ULP-B. RN-A stated she ensures all staff complete the required annual training, and stated she missed the dates of ULP-B training timeline. The licensee's Annual Required Staff Training policy, dated August 1, 2021, verified all staff that perform direct care services will complete at least eight (8) hours of annual training for each 12 months of employment. No further information was provided.	01500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36295	A. BUILDING: _____ B. WING _____	07/19/2024

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01500	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		

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

Type: Full
Date: *07/17/24*
Time: 13:30:15
Report: 1050241127

Food and Beverage Establishment Inspection Report

Location:

Prosper Home Health & Transpor
10025 Colfax Avenue South
Bloomington, MN55431
Hennepin County, 27

Establishment Info:

ID #: 0037780
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6128761187
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 180F Degrees Fahrenheit
Location: DIshwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/Milk
Temperature: 41F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

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

Announced inspection with Andrew Spaulding (MDH-FPLS) and Ifrah Ali. Jolene Bertelsen was the lead Health Regulation Division Nurse Evaluator.

Confirmed 4 residents for capacity was on site at the time of inspection.

Residence does not have a deep freezer kept inside garage. All temps verified and secondary thermometer in use Meals are prepared on site staff does keep leftovers for an allowance of 3 days with the use of labeling.

Spill kit by Spill Magic used as Vomit clean up in powder form. Calibration and test strip logs are utilized and kept posted in kitchen.

A two basin sink is located in the kitchen with one basin designated for hand washing. There was also another basin used to sanitize even though a high temp dishwasher is being used. Staff still plan to use this set but mention it was not necessary.

Food and Beverage Establishment Inspection Report

Current pest control company servicing is Plunketts every month. There was no pest seen on site 7/16/24.

Discussed the following:
-Employee illness policy and logging requirements
-Hand Washing
-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 1050241127 of 07/17/24.

Certified Food Protection Manager Ifrah D. Ali

Certification Number: FM108476 Expires: 10/22/24

Inspection report reviewed with person in charge and emailed.

Signed:_____
Ifrah D. Ali
Owner

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