Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 27, 2023

Licensee
Ezekiel's House
13050 Pioneer Trail
Eden Prairie, MN 55347

RE: Project Number(s) SL33726015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 30, 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.

The 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. 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 651-281-9796

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33726	A. BUILDING: ______ B. WING ______	08/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTIVATE HOME SERVICES	**13050 PIONEER TRAIL EDEN PRAIRIE, MN 55347**

(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: SL33726015 On August 29, 2023, through August 30, 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 9 active residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an	0 110		

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0 110	Continued From page 1 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 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 August 29, 2023, at approximately 10:00 a.m., RN-A stated LALD-C was the LALD for licensee. LALD-D obtained an assisted living director license on July 30, 2021. On August 22, 2023, at 1:00 p.m., the Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-C held a current assisted living director license. The BELTSS website did not indicate LALD-C was listed as the Director of Record for the licensee. On August 22, 2023, at approximately 2:00 p.m., administrator (A)-D acknowledged LALD-D was not listed as the Director of Record for licensee.	0 110		

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0 110	Continued From page 2 A-D stated when he completed the paperwork for BELTSS, he indicated LALD-C was the LALD for several of the licensee's establishments. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all nine (9) residents in 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) 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report,	0 480		

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0 480	Continued From page 3 dated August 29, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of an annual TB risk assessment and a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-B).	0 660		

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0 660	Continued From page 4 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: The licensee's TB risk assessment dated August 20, 2021, indicated the licensee was a low risk setting for TB transmission. The licensee lacked an updated TB risk assessment. ULP-B had a hire date of December 3, 2018. ULP-B provided direct care to residents of the assisted living. ULP-B's employee record lacked a completed TB screening form and documentation of a two-step TST or other evidence of TB screening such as a blood test. ULP-B's employee record indicated ULP-B had a chest x-ray completed at the time of hire. During an interview on August 29, 2023, at 1:30 p.m., RN-A stated she was not aware the licensee's TB risk assessment was not current and that ULP-B did not have evidence of TB screening or TB testing. RN-A stated ULP-B did have a chest x-ray completed at the time of hire due to her past history of testing positive when completing a TST. RN-A stated she was not aware of the current TB control guidelines indicating employees were to complete a TST or blood test at the time of hire. RN-A stated she thought if an employee's TST was positive in the past they would automatically receive a chest x-ray in place of a TST.	0 660		

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0 660	Continued From page 5 During interview on August 29, 2023, at 2:30 p.m., LALD-C stated she was not aware of the current CDC TB guidelines and stated that most of the licensee's employees would test positive if they received a TST. Because of this knowledge they were automatically told to obtain a chest x-ray to rule out TB. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, noted baseline screening for all health care workers (HCW) included a history and symptom screen, and testing for the presence of TB infection. The regulations noted a blood test should include the date of the test. The licensee's Tuberculosis Prevention and Control undated policy indicated at the time of hire, all staff will be screened for TB. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;	0 780		

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0 780	Continued From page 6 (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. 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 August 30, 2023, approximately from 10:15 a.m. to 12:15 p.m., survey staff toured the facility with the administraor (A)-D and unlicensed professional (ULP)-B. It was observed that the	0 780		

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0 780	Continued From page 7 sleeping rooms that were equipped with smoke alarms were not interconnected with the other smoke alarms in the dwelling unit so that actuation of one alarm would cause all alarms to operate. This deficient condition was visually verified by A-D and ULP-B accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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	0 800		

Minnesota Department of Health

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0 800		0 800		

Continued From page 8

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 August 30, 2023, approximately from 10:15 a.m. to 12:15 p.m., survey staff toured the facility with the administraor (A)-D and unlicensed professional (ULP)-B. It was observed that there was water leaking and black staining on the tiles and grout under the sink in the bathroom near bedroom #9.

It was observed that the emergency lighting in the back stairwell was burned out or not working. Survey staff attempted to flip the switch multiple times to get the light to come on, but nothing was happening. Lights in the path of egress must be maintained in proper working condition.

It was observed that the laundry room in the basement had a 10" x 10" hole in the wall from previous plumbing work. There was a liquid or foam of some type dripping on or from the pipes that was running down the wall behind the washing machine. The vapor barrier and insulation were exposed to the laundry room through the large hole. Laundry rooms are a higher hazard space and this was a potential location where pests, water vapor, smoke, or fire could access the building structure and cause significant damage prior to staff or residents knowing.

A-D and ULP-B visually verified these deficient findings at the time of discovery.

TIME PERIOD FOR CORRECTION: Seven (7)

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0 800	Continued From page 9 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 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.	0 810		

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0 810	Continued From page 10	0 810		

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, 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 August 30, 2023, at approximately 1:00 p.m. with the administraor (A)-D and unlicensed professional (ULP)-B 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, A-D verified that the fire safety and evacuation plan for the facility lacked these provisions.

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0 810	Continued From page 11 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, A-D 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 plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, A-D verified that the fire safety and evacuation plan for the facility lacked these provisions. 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. During interview, A-D and ULP-B stated the licensee did not have documentation or a policy on employee training on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provide annual training to 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, A-D and ULP-B stated that the facility did not have documentation on offering resident training on the fire safety and evacuation plan.	0 810		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOTIVATE HOME SERVICES	13050 PIONEER TRAIL EDEN PRAIRIE, MN 55347

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 Record review of the available documentation indicated that the licensee was completing the required evacuation drills, but the licensee did not have a policy on performing evacuation drills, A-D verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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

Type: Full
Date: *08/29/23*
Time: 14:15:54
Report: 1021231247

Food and Beverage Establishment Inspection Report

Location:
Ezekiel's House
13050 Pioneer Trail
Eden Prairie, MN55347
Hennepin County, 27

Establishment Info:
ID #: 0037964
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9528480935
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.

The following orders were issued during this inspection.

3-600 Food Identity

3-601.11

MN Rule 4626.0425 Meet the standard of identity and general requirements of the Code of Federal Regulations for all packaged foods.

AN OPEN PREPACKAGED CONTAINER WITH SLICED CHICKEN BREAST IN THE KITCHEN REFRIGERATOR HAD AN EXPIRATION DATE OF 08/11/23. STAFF DISCARDED THE CONTAINER OF SLICED CHICKEN BREAST DURING INSPECTION. CORRECTED ON-SITE.

Comply By: 08/29/23

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE AMBIENT TEMPERATURE OF THE KITCHEN REFRIGERATOR MEASURED 47F. STAFF MOVED ANY TCS FOODS (MILK, EGGS, AND SLICED CHEESE) TO THE BASEMENT COOLER. STAFF ALREADY CALLED TO GET REFRIGERATOR SERVICED. SEE COMMENTS.

Comply By: 08/29/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Final Utensil Surface Temp: = at 170 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 51 Degrees Fahrenheit - Location: SLICED CHICKEN BREAST - KITCHEN REFRIGERATOR *DISCARDED
Violation Issued: Yes

Process/Item: Cooling
Temperature: 52 Degrees Fahrenheit - Location: MILK - KITCHEN REFRIGERATOR, COOLING FROM AMBIENT AND MOVED TO BASEMENT COOLER
Violation Issued: No

Process/Item: Ambient Temperature
Temperature: 47 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: Yes

Process/Item: Ambient Temperature
Temperature: 40 Degrees Fahrenheit - Location: BASEMENT COOLER
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH HOUSE MANAGER/CFPM, LUCY WANGARI KARUGU AND HEALTH REGULATION DIVISION NURSE EVALUATOR, ELYSE JONES .

MN Rule 4626.0735AB
STAFF ARE NOT ABLE TO STORE ANY TCS FOOD ITEMS IN THE KITCHEN REFRIGERATOR UNTIL IT IS ABLE TO MAINTAIN TCS FOOD ITEMS 41F AND BELOW. IN THE MEANTIME ESTABLISHMENT WILL STORE TCS FOOD ITEMS IN THE BASEMENT COOLER. STAFF WILL SEND INSPECTOR PROOF THAT THE KITCHEN REFRIGERATOR WAS SERVICED/REPAIRED.

THIS IS A PARTIAL RESIDENTIAL HOME. CURRENTLY THERE ARE NINE RESIDENTS WITH A MAXIMUM NUMBER OF NINE RESIDENTS.

PER CONVERSATION WITH LUCY, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

THE KITCHEN HAS A RESIDENTIAL VENTILATION HOOD AND LAMINATE COUNTERTOPS. EQUIPMENT AND PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

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 1021231247 of 08/29/23.

Certified Food Protection Manager: LUCY WANGARI KARUGU

Certification Number: FM107615 Expires: 08/25/24

Inspection report reviewed with person in charge and emailed.

Signed: ____________________

LUCY WANGARI KARUGU
HOUSE MANAGER/CFPM

Signed:

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us