Electronically Delivered

August 22, 2022

Administrator
New Challenges Inc - Afton
6880 St. Croix Trail South
Hastings, MN 55033

RE: Project Number(s) SL28126015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 2, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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 enclosed State Form documents the state licensing orders. The Department of Health 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 . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 Department of Health within 15 calendar days of the correction order receipt date.

A state licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28126	A. BUILDING: _____ B. WING _____	08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CHALLENGES INC - AFTON	6880 ST. CROIX TRAIL SOUTH HASTINGS, MN 55033

(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 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: SL28126015 On August 1, 2022, through August 2, 2022, 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 eight residents receiving services under the provider's 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 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, dated August 1, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 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 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 a two-step TST (tuberculin skin test) for one of one employee (unlicensed personnel (ULP)-C) 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, but was not likely to	0 660		

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0 660	Continued From page 3 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-C was hired on April 21, 2022, to provide assisted living services for the licensee's residents. On August 2, 2022, from 7:45 a.m. to 8:45 a.m., ULP-C administered medications to licensee residents. ULP-C's employee record indicated a history and symptom screening was completed on April 19, 2022 and a first step TST was read on April 21, 2022, as negative with 0 millimeters of induration. ULP-C's employee record lacked documentation a second step TST was completed, as required. During an interview on August 2, 2022, at 12:45 p.m., licensed assisted living director (LALD), confirmed ULP-C lacked a second step TST, as required. The licensee's Tuberculosis Screening policy dated August 1, 2021, verified a two-step Mantoux would be completed for new staff and documented on the Baseline TB screening Tool for Staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 780	Continued From page 4	0 780		
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; (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 working smoke alarm outside the hallway of the two-bedroom apartment. This has the potential to directly affect the 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	0 780		

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0 780	Continued From page 5 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 2, 2022, approximately from 12:15 p.m. to 1:20 p.m., survey staff toured the home with the licensed assisted living director (LALD)-D, and from 1:20 p.m. to 1:50 p.m. the LALD-D left to take a phone call and was replaced with the licensed assisted living director (LALD)-A for the remaining tour. At approximately 1:25 p.m., survey staff observed that the smoke alarm outside the two-bedroom apartment failed to sound when the smoke alarm near the one-bedroom apartment was activated. The LALD-A verified the finding. On August 2, 2022, at approximately 2:50 p.m., during the exit interview, the LALD-A and the LALD-D acknowledged the finding. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 780		
0 790 SS=F	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	0 790		

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0 790	Continued From page 6 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 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain portable fire extinguishers in accordance with the State Fire Code as required by MN Statute 144G.45 Subd(a)(2). This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 residents). The findings include: On August 2, 2022, approximately from 12:15 p.m. to 1:20 p.m., survey staff toured the home with the licensed assisted living director (LALD)-D, and from 1:20 p.m. to 1:50 p.m. the LALD-D was replaced with the licensed assisted living director (LALD)-A for the remaining tour. During the tour, survey staff observed the following: MAIN FLOOR The travel distance to the nearest fire extinguisher on the first-floor hallways was at	0 790		

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0 790	Continued From page 7 approximately 100 feet distance which exceeded the 75 feet maximum distance allowed. The LALD-A verified the finding and commented that they will add an extinguisher at the end of the hallway near resident rooms #1 and #2. SECOND FLOOR The hallways on the second floor were not provided with a portable fire extinguisher. The LALD-D verified the finding and agreed to provide one. On August 2, 2022, at approximately 2:50 p.m., during the exit interview, the LALD-A and the LALD-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) 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 physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents	0 800		

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0 800	Continued From page 8 and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings are: On August 2, 2022, approximately from 12:15 p.m. to 1:20 p.m., survey staff toured the home with the licensed assisted living director (LALD)-D, and from 1:20 p.m. to 1:50 p.m. the LALD-D was replaced with the licensed assisted living director (LALD)-A for the remaining tour. During the tour, survey staff observed the following: 1. The door to resident room #1 was missing a mold casing on the exterior of the resident room door. The LALD-D commented that it was sitting in the corner. 2. Window security locks on the double-hung windows for the resident rooms (#1 through #6) on the main floor were damaged and in need of repair and/or replacement for the safety and security of residents in the room. 3. The egress windows in resident rooms (#1 through #6) on the main floor were not maintained to be easily operable for immediate egress use during an emergency. This was evident as survey staff observed the LALD-D slowly opened the egress windows with	0 800		

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0 800	Continued From page 9	0 800		

challenges and difficulties lifting the lower pane of the double-hung windows. The LALD-D agreed the windows had not been maintained.

4. Windowsills throughout the resident rooms were dusty and layered with dirt. The LALD-D agreed that the windowsills needed to be cleaned.

5. The locks on the two side exit doors of the home failed to lock from the inside for the security of the residents from unwanted or unauthorized entry from the outside. The LALD-D stated that she was not aware of the doors not being able to lock from the inside.

6. An extension cord was used in room #6 with a car battery charger plugged in the outlet that posed a potential electrical fire hazard from overloading the electrical circuits and the risk of shock to the resident and/or staff. The LALD-D agreed to review the situation for the safety of the resident.

7. The window in the second-floor hallway next to the one-bedroom apartment was missing a screen.

8. The front entrance door hardware had a door handle that required a key on the inside to exit the home. Survey staff explained to the LALD-A that the front door is one of the means of escape in the home and must not be locked against egress. In addition, any key lock in the means of egress inside the home that requires prior and/or special knowledge will cause delay and impediment in proper exiting of the home during a fire or similar emergency. The LALD-D stated that she understood, and they do not use the key lock from the inside but just the deadbolt lock and will

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0 800	Continued From page 10 have maintenance staff remove any key lock from the inside. 9. The water to the tub located in the central bathroom was turned off and survey staff asked about the use of the tub. The LALD-D explained that the residents preferred using showers. Because the tub had no running water, survey staff explained to the LALD-D that the tub drain trap would be dried out which would allow sewer gas to enter the environment creating health risks to the residents and employees. 10. The elevator had not been inspected annually as required by obtaining an Elevator Certificate of Operation to be in service for elevators in homes for more than six unrelated persons. The LALD-D stated that she has been looking into this. Survey staff suggested they reach out to the Minnesota Department of Labor and Industry, Elevator Unit, for operating information and permit requirements. On August 2, 2022, at approximately 2:50 p.m. during the exit interview, the LALD-A and the LALD-D acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) 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	0 810		

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0 810	Continued From page 11 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 observation, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, required employee training, and the minimum number of evacuation drills. This has the potential to directly affect the safety of all residents receiving care, staff, and visitors. This practice resulted in a level two violation (a	0 810		

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0 810	Continued From page 12 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: On August 2, 2022, at approximately 2:00 p.m. survey staff reviewed the facility's fire safety and evacuation documentation, the evacuation drill, and the training records. Document and record review indicated the following: FIRE SAFETY AND EVACUATION PLAN 1) The plan documentation lacked fire protection procedures for residents. 2) The plan documentation lacked a building evacuation floor plan for the second floor to show the location and number of sleeping rooms. In addition, the evacuation floor plan on the main level incorrectly showed the patio door to a fenced-in area as a main exit. 3) The home's fire policy (undated), 9.06, lacked site-specific fire protection procedures for employees. The documentation incorrectly stated that the home was provided with magnetic door holders and smoke compartments. 4) The plan documentation lacked fire protection procedures necessary for addressing resident movement, evacuation, and relocation including unique resident-specific situations during an evacuation. Unique situations during an evacuation may be residents who have mobility limitations, are non-ambulatory, bedridden, have a cognitive impairment, or any residents needing assistance during an evacuation and must be addressed in the fire safety and evacuation plan	0 810		

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0 810	Continued From page 13 documentation. During the tour, survey staff observed wheelchair residents that may need additional assistance during a fire or other emergency evacuation. EVACUATION DRILLS The review of the facility's documented drill record indicated the licensee failed to show compliance with the minimum number of required employee fire and evacuation drills performed to date. The evacuation drill record provided for review showed one drill performed dated 6/17/22 at 2:00 p.m. The LALD-A stated that she could not locate the other drill records. TRAINING of FIRE SAFETY and EVACUATION The home policy documentation 9.06, dated August 1, 2022, indicated the content of employee training on the fire safety and evacuation plan upon hiring and at least twice per year thereafter, but the licensee lacked documented records of employee training to show compliance with the training frequency requirements. Record provided for review was one fire safety and evacuation training provided in the last year with employee signatures, dated July 13, 2022. On August 2, 2022, at approximately 2:50 p.m., during the exit interview, the LALD-A and the LALD-D acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 900 SS=C	144G.50 Subdivision 1 Contract required	0 900		

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0 900	Continued From page 14 (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 900		

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0 900	Continued From page 15 licensee failed to execute a written contract with the required content for one of one resident (R1) with record reviewed. This had the potential to affect all residents. 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: R1 had an admission date of August 1, 2021. R1's record lacked a current written contract to include: -housing -assisted living services, whether provided directly by the facility or by management agreement or other agreement; and -the resident's service plan, if applicable. During an interview on August 2, 2022, at 12:45 p.m., licensed assisted living director (LALD)-A confirmed the licensee has developed a contract to include all the required content, but had not distributed the contract to the licensee clients, and would ensure this was completed. The licensee's Signing an Assisted Living Contract policy dated August 1, 2022, confirmed "a signed Assisted Living contract signed and received by the facility." No further information was provided.	0 900		

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0 900	Continued From page 16 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 950 SS=D	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 950		

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0 950	Continued From page 17 licensee failed to identify a designated representative for one of one residents (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, 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 findings include: R1's service plan, dated August 1, 2021, indicated R1 received services including assistance with activities of daily living, housekeeping and medication management. R1's record did not contain a notice for the resident to identify a designated representative or have documentation R1 declined to name a designated representative. During an interview on August 2, 2022, at 12:45 p.m., licensed assisted living director (LALD)-A confirmed R1 lacked documentation of a designated representative or documentation the resident refused to name a designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		

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01370	Continued From page 18	01370		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various	01370		

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01370	Continued From page 19 emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations for the required topics for one of one unlicensed personnel (ULP-C) with record 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 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-C was hired on April 21, 2022, to provide assisted living services for the licensee's residents. ULP-C's employee record lacked evidence to indicate ULP-C completed training and/or practical skills evaluations as required in the following areas: -documentation requirements for all services provided -reports of changes in the resident's condition to the supervisor designated by the facility -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal	01370		

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01370	Continued From page 20 hygiene and grooming, including: -hair care and bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids; and -dressing and assisting with toileting -standby assistance techniques and how to perform them -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family On August 2, 2022, at 12:45 p.m., licensed assisted living director (LALD)-A stated the licensee employees are trained by the RN and complete a training manual upon hire. LALD-A stated she would review and ensure all required areas of training and competency testing are completed by ULP-C. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated the above areas of training and competency testing will be completed "prior to the delegation of services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include:	01380		

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01380	Continued From page 21 (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations for the required topics for one of one unlicensed personnel (ULP-C) with record 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 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-C was hired on April 21, 2022, to provide assisted living services for the licensee's residents. ULP-C's employee record lacked evidence to indicate ULP-C completed training and/or	01380		

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01380	Continued From page 22 practical skills evaluations as required in the following areas: -observing, reporting, and documenting resident status -reading and recording temperature, pulse, and respirations of the resident -range of motioning and positioning On August 2, 2022, at 12:45 p.m., licensed assisted living director (LALD)-A stated the licensee employees are trained by the RN and complete a training manual upon hire. LALD-A stated she would review and ensure all required areas of training and competency testing are completed by ULP-C. The licensee's Competency Training Evaluations policy dated August 1, 2021, indicated the above areas of training and competency testing will be completed "prior to the delegation of services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01560 SS=D	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and	01560		

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01560	Continued From page 23 (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff completed the required training for all topics of dementia care for one of one unlicensed personnel (ULP)-C 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, 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-C was hired on April 21, 2022, to provide assisted living services for the licensee's residents. ULP C's record lacked documentation of training in the following: (1) an explanation of Alzheimer's disease and other dementias (2) assistance with activities of daily living (3) problem solving with challenging behaviors (4) communication skills and (5) person-centered planning and service delivery	01560		

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01560	Continued From page 24 On August 2, 2022, at 12:45 p.m., licensed assisted living director (LALD)-A stated the licensee employees are trained by the RN and complete a training manual upon hire. LALD-A stated she would review and ensure all required areas of training and competency testing are completed by ULP-C. The licensee's Assisted Living Licensed Facilities policy, dated June 2021, confirmed the direct care staff will complete eight hours of initial training within 160 working hours of the first day of employment, and would include the above required training. No further information was provided. TIME PERIOD TO CORRECT: Fourteen (14) day	01560		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions	01730		

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01730	Continued From page 25 relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of one resident (R1). This had the potential to affect all eight licensee 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28126	A. BUILDING: _____ B. WING _____	08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CHALLENGES INC - AFTON	6880 ST. CROIX TRAIL SOUTH HASTINGS, MN 55033

(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
01730	Continued From page 26 or has the potential to affect a large portion or all of the residents). The findings included: R1's service plan, dated August 1, 2021, indicated R1 received services including medication management. R1's record lacked an Individualized Medication Management Plan (IMMP) to include the following: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis -identification of medication management tasks that may be delegated to unlicensed personnel -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services On August 2, 2022, at 12:45 p.m., licensed assisted living director (LALD)-A stated the service plan for each resident included medication administration daily and medication set up by the nurse weekly. LALD-A verified R1 lacked the above medication management plan requirements. The licensee's Medication Management Individualized Plan dated August 1, 2021, confirmed the plan would include the above required documentation. No further information was provided.	01730		

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01730	Continued From page 27 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1) with records reviewed. This had the potential to affect all eight licensee 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) 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: R1's record lacked documentation of medication set-up to include the date of the medication setup, name of medication, quantity of dose, times to be administered, route of administration, and the name of person completing medication setup. R1's service plan, dated August 1, 2021,	01770		

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	28126	A. BUILDING: _____ B. WING _____	08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CHALLENGES INC - AFTON	6880 ST. CROIX TRAIL SOUTH HASTINGS, MN 55033

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01770	Continued From page 28 indicated R1 received medication management services. R1's prescriber orders dated October 15, 2021, included an antilipemic, an antibiotic, an antidepressant, and an antidiarrheal. On August 2, 2022, from 7:45 a.m. to 8:45 a.m., ULP-C was observed to empty R1's morning medications from a mediset into a medication cup and administer the medications to R1. ULP-C stated the registered nurse (RN) sets up the medications into medisets weekly and licensee ULP's will administer the medications to the licensee residents. On August 2, 2022, at 12:45 p.m., licensed assisted living director (LALD)-A confirmed the RN sets up medications for each resident into the medisets, and the ULP's administer the medications to licensee residents. LALD-A verified the medication setup for each resident was not documented in the resident's record to include the required content noted above. The licensee's Medication Management-Administration & Setup policy dated August 1, 2021, indicated "a licensed nurse will correctly and accurately document any medication setup provided." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28126	A. BUILDING: _____ B. WING _____	08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CHALLENGES INC - AFTON	6880 ST. CROIX TRAIL SOUTH HASTINGS, MN 55033

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01940	Continued From page 29 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 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 interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28126	A. BUILDING: _____ B. WING _____	08/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CHALLENGES INC - AFTON	6880 ST. CROIX TRAIL SOUTH HASTINGS, MN 55033

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01940	Continued From page 30	01940		

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:

R1's service plan dated August 1, 2021, lacked a written statement of the treatment the resident received to include Continuous Positive Airway Pressure (CPAP).

Physician orders dated October 15, 2021, included orders for CPAP (machine that delivers constant air pressure to assist with breathing while sleeping) daily for obstructive sleep apnea.

R1's record lacked evidence of an individualized treatment or therapy management plan which included the following for CPAP use:
- a statement of the type of services that would be provided
- documentation of specific resident instructions relating to the treatments or therapy administered
- identification of treatment or therapy tasks that would be delegated to ULP
- procedures for notifying an RN or appropriate licensed health professional when a problem arises with treatments or therapy services
- any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment or therapy was administered as prescribed; and monitoring of treatment or therapy to prevent possible complications or adverse reactions.

On August 2, 2022, at 12:45 p.m., licensed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01940	Continued From page 31 assisted living director (LALD)-A confirmed R1 lacked a treatment and therapy plan for CPAP. LALD-A stated R1 manages the CPAP, and staff will assist, if needed. The licensee's Treatment & Therapy Management Plan dated August 1, 2021, verified the treatment and therapy plan would include the above required documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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

Type: Full
Date: *08/01/22*
Time: 10:30:00
Report: 1005221084

Food and Beverage Establishment Inspection Report

Location:
New Challenges Inc - Afton
6880 St. Croix Trail South
Hastings, MN55033
Washington County, 82

Establishment Info:
ID #: 0039313
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6514540161
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.

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

THERMOLABELS WERE LEFT ON SITE FOR OPERATOR TO RUN THROUGH DISH WASHERS. OPERATOR LATER REPORTED TO INSPECTOR THAT THEY WERE NOT ABLE TO ACHIEVE A UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F OR ABOVE.

Comply By: 08/01/22

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

THE ONLY FOOD THERMOMETER AVAILABLE HAD A LARGE DIAMETER PROBE, WHICH WILL NOT ALLOW FOR ACCURATELY TAKING TEMPERATURES OF THIN FOODS.

Comply By: 08/15/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

NO INDICATOR WAS AVAILABLE TO MEASURE THE UTENSIL SURFACE TEMPERATURE IN THE DISHWASHERS. DISCUSSED OPTIONS. SINGLE USE THERMOLABELS WERE LEFT ON

SITE FOR FACILITY TO USE UNTIL THEY CAN PROVIDE THEIR OWN.
Comply By: 08/15/22

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.12A

MN Rule 4626.0275A Store food preparation or dispensing utensils in the food with the handles above the top of the food within the container.

THE SCOOP FOR THE ICE WAS STORED WITH THE HANDLE IN CONTACT WITH THE ICE. STORE WITH HANDLE ABOVE THE ICE, OR STORE SCOOP ON A CLEAN SURFACE OR SEPARATE CONTAINER.
Comply By: 08/01/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

NO SIGN POSTED AT HANDWASHING SINK. SIGN LEFT ON SITE.
Comply By: 08/01/22

Food and Equipment Temperatures

Process/Item: Cold Hold/POT PIE
Temperature: 40 Degrees Fahrenheit - Location: LEFT REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/CHICKEN SALAD
Temperature: 38 Degrees Fahrenheit - Location: LEFT REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/RICE
Temperature: 39 Degrees Fahrenheit - Location: LEFT REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/REFRIED BEANS
Temperature: 35 Degrees Fahrenheit - Location: LEFT REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 37 Degrees Fahrenheit - Location: RIGHT REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/TURKEY
Temperature: 37 Degrees Fahrenheit - Location: RIGHT REFRIGERATOR
Violation Issued: No

Food and Beverage Establishment Inspection Report

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

INSPECTION COMPLETED WITH JEFF JOHANSON (MDH) AND CENTER DIRECTOR, SUE FRIES. INSPECTION WAS REVIEWED WITH HRD NURSE EVALUATOR, JOLENE BERTELSEN.

IN ADDITION TO ORDERS ON REPORT, DISCUSSED:

-EMPLOYEE ILLNESS
-HANDWASHING AND BARE AND CONTACT / GLOVE USE
-DATE MARKING
-COOK TEMPERATURES FOR RAW ANIMAL FOODS

ESTABLISHMENT'S PREVIOUS MN CERTIFIED FOOD PROTECTION MANAGER (CFPM) JUST LEFT, SO A NEW EMPLOYEE HAS COMPLETED A FOOD SAFETY COURSE. PER FOOD CODE, FACILITY HAS 60 DAYS TO PROVIDE A NEW MN CFPM. DISCUSSED HAVING EMPLOYEE SUBMIT FOOD SAFETY COURSE TO APPLY FOR MN CFPM.

THERMOLABELS WERE LEFT ON SITE. OPERATOR LATER REPORTED TO INSPECTOR THAT BOTH DISHWASHERS WERE PROVIDING A UTENSIL SURFACE TEMPERATURE LESS THAN 160dF (ONLY ACHIEVING THE 150dF BAR ON THE THERMOLABELS). IF THE DISHWASHERS CANNOT BE REPAIRED OR ADJUSTED, A BOOSTER HEATER MAY BE AN OPTION, OTHERWISE THE UNITS WILL NEED TO BE REPLACED.

THIS FACILITY HAS RESIDENTIAL EQUIPMENT AND FINISHES. ALL FOOD PREPARED IS FOR SAME-DAY SERVICE.

CABINETRY IS WOOD CABINETS WITH HOLLOW ENCLOSED BASES. ALL CABINETS ARE CURRENTLY IN GOOD CONDITION. THEY WILL BE MONITORED AT FUTURE INSPECTIONS AND COULD BE REQUIRED TO BE REPLACED TO MEET CODE IF THEY ARE NO LONGER IN GOOD REPAIR.

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 1005221084 of 08/01/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____

SUE FRIES
PROGRAM DIRECTOR

Signed:_____

Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us