Electronically Delivered

August 9, 2022

Administrator
Living Hope Homes-Audrey's Place
4660 Slater Road #230
Eagan, MN 55122

RE: Project Number(s) SL37868015

Dear Administrator:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an evaluation on July 22, 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
St. Paul, MN 55164-0970

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

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,

Paul Spencer, Supervisor
State Rapid Response Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 651-587-4460 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37868	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES-AUDREY'S PLACE	4660 SLATER ROAD #230 EAGAN, MN 55122

(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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDERS 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: SL37868015 On July 19 through July 22, 2022, the Minnesota Department of Health conducted a survey at the above provider. At the time of the survey and investigation, there were four (5) residents receiving services under the provider's Provisional 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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 1 (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 maintain a comprehensive tuberculosis infection control (TBIC) program according to the most current TBIC guidelines issued by the Centers for Disease Control (CDC) when one of one employee, registered nurse (RN)-A lacked an updated tuberculosis (TB) screening and TB test results. This had the potential to affect all five residents receiving assisted living services. 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).	0 660		

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0 660	Continued From page 2 The findings include: During the entrance conference on July 19, 2022, at 10:25 a.m., the MDH surveyor requested the licensee's TBIC Risk Assessment and employee file for RN-A which included TB screening and training. RN-A was hired by the licensee on May 25, 2022, RN-A ' s employee file lacked evidence of TB screening and testing, but it was marked "x" as completed on the orientation checklist. During an interview on July 20, 2022, at 9:40 a.m., owner (O)-C stated and confirmed RN-A did not have her TB testing completed and did not know why it was marked as completed on the orientation checklist. During interview on July 22, 2022, at 2:30 p.m., RN-A stated that she had not completed TB testing and was scheduled to do so. Facility-provided policy 8.18 Tuberculosis Control, dated June 1, 2022, indicated "All staff whose essential job functions require work within the same air space of assisted living residents shall be screened and tested for tuberculosis. Living Hope Homes has an ongoing program for screening and educating staff on tuberculosis and has an infection control plan for handling persons with active tuberculosis. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 660		

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0 680	Continued From page 3	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently or have completed drills for emergency events. This had the potential to affect all residents receiving services under the assisted living license, staff,	0 680		

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0 680	Continued From page 4 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 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 include: During the entrance conference on July 19, 2022, at 10:25 a.m., the MDH surveyor requested the licensee's emergency preparedness plan (EPP). Licensed assisted living director (LALD)-B stated he was the primary contact for the plan and provided the plan electronically by email. The licensee's plan provided to the surveyors included a Hazard and Vulnerability Assessment Tool, undated, which identified events (such as wildfire, tornado, blizzard) and scored each event based on probability, risk, and severity. On July 19, 2022, 2:10 p.m., the surveyor observed emergency exit diagrams posted on each floor, and emergency exit diagrams were posted in each resident's room. There was no evidence of signage posted or information regarding the licensee's emergency plan. During interview on July 20, 2022, at 11:15 a.m., ULP-D was asked where the EPP was located for staff to review in case of emergency. ULP-D did not know where a plan was located, nor did ULP-D know where the nearest fire extinguisher was located.	0 680		

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0 680	Continued From page 5 During an interview on July 20, 2022, at 11:36 a.m., owner (O)-C stated and confirmed EP testing and drills had not been completed with all staff and residents and the EPP binder information was not readily available for residents, staff or visitors who were in the building. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 680		
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	0 810		

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0 810	Continued From page 6 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, the required training on fire safety and evacuation plan, 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 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 July 20, 2022, 10:50 p.m., survey staff received and reviewed the home's fire safety and evacuation documentation, the evacuation drill, and the training documentation via electronic format. FIRE SAFETY AND EVACUATION PLAN 1)The plan documentation lacked fire protection	0 810		

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0 810	Continued From page 7	0 810		

procedures for residents.
2)The floor plan incorrectly labeled the garage door as an approved exit.
3) The electronic plan documentation was not readily available for employee and visitor access. Survey staff asked the unlicensed personnel-D if she was able to access the emergency preparedness including fire safety and evacuation plan, and she did not know how.

TRAINING
Documentation review showed the licensee lacked documentation of records for employee training on the fire safety and evacuation plan for the home as described in the policy for compliance with Minnesota Statutes, consisting of upon hire and twice a year. Survey staff explained that the fire safety and evacuation training was in addition to the annual required emergency preparedness plan training.

EVACUATION DRILLS
1) The documentation review indicated the lack of fire and evacuation drills performed as required by the home policy dated August 1, 2021, and therefore, not in compliance with Minnesota Statutes. Record review indicated one fire drill performed to date, June 15, 2022, at 12:00 p.m. The owner (O)-C explained the previous licensed assisted living facility failed to carry out the drills.
2) The training and testing documentation policy on page 17 incorrectly showed quarterly employee evacuation drills which was a discrepancy with their own policy dated August 1, 2021, and the requirements of Minnesota Statutes Survey staff explained to the O-C, the training and testing documentation must be reviewed and be updated for accuracy.

On July 20, 2022, 11:35 a.m., at the exit interview

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0 810	Continued From page 8 the O-C acknowledged the findings. O-C agreed to review and revise their policies and procedures and performed fire safety and evacuation drills consistent with the requirements of the Minnesota Statutes. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced	01440		

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01440	Continued From page 9 by: Based on observation, interview and record review, the licensee failed to conduct supervision of unlicensed staff by a registered nurse (RN) at or before 30 days for two of two unlicensed persons (ULP)-D, ULP-F, with employee files reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at 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: During the entrance conference on July 19, 2022, at 10:25 a.m., the MDH surveyor requested the employee files for ULP-D, and ULP-F. During observation on July 20, 2022, at 8:30 a.m., ULP-F performed stretching to resident (R)-1's left foot and applied an orthotic foot brace. At the time of observation, ULP-F stated she completed a lot of training through Educare and other staff. During observation on July 20, 2022, at 9:03 a.m., ULP-D administered medications to R1. During an interview on July 20, 2022, at 10:15 a.m., owner (O)-C verified that the 30-day supervision of ULP staff had not been completed by the previous RN and confirmed the documentation was not in the employee files. During interview on July 20, 2022, at 10:30 a.m., ULP-D stated she completed Educare training	01440		

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01440	Continued From page 10 and had received some training through other staff. During interview on July 22, 2022, at 2:30 p.m., RN-A stated she had not verified staff were competent with medication administration or delegated treatments since her hire on as the RN. Facility-provided policy titled 7.15 Medications & Treatments - Administration & Delegation dated August 1, 2021, indicated ordered or prescribed medications may be administered by unlicensed personnel who have been delegated by a registered nurse. Prior to a ULP providing delegated medication administration, 7. Written records, signed by a RN, shall be maintained regarding ULP training and competency testing of delegated medication administration and treatment/therapy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01440		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 11 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct the required assessment at 14-days for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at 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 admitted to the facility August 1, 2021 with diagnoses that included stroke and left sided weakness. All assessments for R1 were requested. R1 ' s medical record included an admission assessment dated October 30, 2021. The next completed assessment was a clinical update for a fracture dated January 13, 2022. R1 ' s medical	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37868	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIVING HOPE HOMES-AUDREY'S PLACE	4660 SLATER ROAD #230 EAGAN, MN 55122

(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
01620	Continued From page 12 record lacked a 14-day assessment completed by an RN. During an interview on July 22, 2022, at 2:30 p.m., RN-A stated the previous RN did not complete the required 14-day assessment for R1 and therefore one was not done. The licensee-provided policy titled Assessment schedules, indicated that resident reassessment and monitoring will occur no more than 14 calendar days after the initiation of services. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01620		

Minnesota Department of Health

625 North Robert Street
Saint Paul, MN
651-201-5000

Type: Full
Date: *07/19/22*
Time: 10:00:00
Report: 8087221171

Food and Beverage Establishment Inspection Report

Location:
Living Hope Homes - Audrey'S P
5641 Babcock Trail
Inver Grove Heights, MN55077
Dakota County, 19

Establishment Info:
ID #: 0038674
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514247163
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: DELI MEAT
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: MILK
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: YOGURT
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding: COTTAGE CHZ
Temperature: 40 Degrees Fahrenheit - Location: STAND-UP REFRIGERATOR
Violation Issued: No

Process/Item: Ambient Air
Temperature: -10 Degrees Fahrenheit - Location: STAND-UP FREEZER
Violation Issued: No

Type: Full
Date: *07/19/22*
Time: 10:00:00
Report: 8087221171
Living Hope Homes - Audrey'S P

Food and Beverage Establishment Inspection Report

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF SPECIAL INVESTIGATOR AND NURSE EVALUATOR CHRISTINE BLUHM.

CABINETS ARE HARDWOOD AND FLOORS ARE LAMINATE. CEILING IS KNOCK DOWN AND IS ROUGH IN TEXTURE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

MAYTAG BRAND DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

2 BIN STAINLESS STEEL SINK HAS ONE BIN AS A DESIGNATED HAND WASHING SINK.

INSPECTION REPORT EMAILED TO SPECIAL INVESTIGATOR AND NURSE EVALUATOR CHRISTINE BLUHM.

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 8087221171 of 07/19/22.

Certified Food Protection Manager: JESSICA J. DUMER

Certification Number: FM111465 Expires: 02/02/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
JESSICA J. DUMER
FOOD SERVICES MANAGER

Signed: _____
John Boettcher
Public Health Sanitarian 3
St. Paul, MN / Freeman
651-201-5076
john.boettcher@state.mn.us