DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 15, 2022

Administrator
Truman Manor Apartments
402 North 4th Avenue East
Truman, MN 56088

RE: Project Number(s) SL30285015

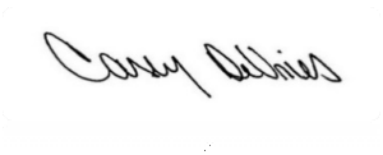
Dear Administrator:

On September 13, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the July 13, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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Electronically Delivered

August 1, 2022

Administrator
Truman Manor Apartments
402 North 4th Avenue East
Truman, MN 56088

RE: Project Number SL30285015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 13, 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, the following fines are assessed pursuant to this evaluation:

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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,

Jessie Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jessica.Chenze@state.mn.us
Phone: 218-332-5175| Fax: 218-332-5196

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30285	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUMAN MANOR APARTMENTS	402 NORTH 4TH AVENUE EAST TRUMAN, MN 56088

(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: SL#30285015 On July 11, 2022, through July 13, 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 13 residents; 11 receiving services under the provider's Assisted Living license. An immediate correction order was identified on July 11, 2022, issued for SL#30285015, tag identification 2310. On July 12, 2022, the immediacy of correction order 2310 was removed; however, non-compliance remains at a scope and level of I.	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 issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the 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 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 July 11, 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		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure as well as the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 550		

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0 550	Continued From page 3 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 11, 2022, at 2:00 p.m., the surveyor noted a bulletin board on the wall by the resident lounge area that contained the staff posting, the month's menu, and activity schedule; however, there was no evidence of the grievance procedure or contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On July 12, 2022, at 2:40 p.m., licensed assisted living director (LALD)-A confirmed the content noted above was not posted as required. LALD-A indicated the signs may have been taken down when the licensee had painted the wall, and never got hung back up. The licensee's Assisted Living Required Postings and Disclosures policy undated, identified postings required: grievance procedure (conspicuous location). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and	0 640		

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0 640	Continued From page 4 suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and 911 emergency number as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On July 11, 2022, at 2:00 p.m., the surveyor noted a bulletin board on the wall by the resident lounge area that contained the staff posting, the month's menu, and activity schedule; however, there was no evidence of posting the MAARC hotline in the common areas of the facility or 911 phone number.	0 640		

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0 640	Continued From page 5 On July 12, 2022, at 2:40 p.m., licensed assisted living director (LALD)-A confirmed the content noted above was not posted as required. LALD-A indicated the signs may have been taken down when the licensee had painted the wall, and never got hung back up. The licensee's Assisted Living Required Postings and Disclosures policy undated, identified postings required: 911 emergency number in common areas and by phones provided by the facility and Minnesota Adult Abuse Reporting Center (MAARC) information and reporting number. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated December 21, 2021, identified the licensee would support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: a. posting the 911 emergency number in common areas and near telephones provided by the assisted living facility. b. posting information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 6 (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 post emergency exit diagrams in the required areas on each floor. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 680		

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0 680	Continued From page 7 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 11, 2022, at 2:00 p.m., the surveyor observed no emergency exit diagrams in the hallways of either first or second floor of the licensee's building. On July 13, 2022, at 1:42 p.m., environmental services director (ESD)-F confirmed the licensee lacked exit diagrams on each floor and indicated he was not aware of the requirement. The licensee's Assisted Living Required Postings and Disclosures policy undated, identified postings required: emergency exit diagrams on each floor. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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	0 780		

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0 780	Continued From page 8 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 smoke alarms in all residents sleeping rooms. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 July 13, 2022, between 9:30 a.m. and 11:30 a.m., survey staff toured the facility with environmental services director (ESD)-F. During the facility tour, survey staff observed that all sleeping rooms did not have smoke alarms.	0 780		

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0 780	Continued From page 9 ESD-F verbally confirmed survey staff observations during the facility tour and stated that all of the residents sleeping rooms did not have smoke alarms. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for tow of two residents (R1, R2) with record reviewed. 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 the residents).	0 970		

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0 970	Continued From page 10 The findings include: R1's assisted living contract dated December 28, 2021, and R2's assisted living contract dated December 30, 2021, included two clauses that indicated the resident would waive the facility's liability for health, safety, or personal property of a resident. -Page 15, section 2 of the contract indicated: Resident would indemnify and hold harmless the provider, its employees and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of the use by resident of the rented premises or any other part of the provider's property, or caused wholly or in part by an act or omission of resident or resident's guests or agents. -Page 15, section 4 of the contract indicated: Provider is not liable to resident or resident's guests for any injury, death or property damage occurring in the apartment unit or on provider's premises unless such injury, death or property damage occurred as a result of an equipment malfunction or hazardous conditions within the building not caused by the resident or resident's guests. On July 13, 2022, at 9:23 a.m., registered nurse (RN)-B verified R1 and R2's contract included the above content, and stated the same contract was utilized for all residents at the facility. RN-B stated she had an addendum to the contract removing that language but had not given it to any of the residents yet.	0 970		

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	30285	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUMAN MANOR APARTMENTS	402 NORTH 4TH AVENUE EAST TRUMAN, MN 56088

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0 970	Continued From page 11 The licensee lacked a policy for Assisted Living Licensure contract requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01370 SS=E	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;	01370		

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01370	Continued From page 12 (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 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 observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for two of two unlicensed personnel (ULP-D, ULP-E) 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D and ULP-E's record lacked evidence of the following education and/or competencies had been completed prior to providing direct cares: - reports of changes in the client's condition to the supervisor designated by the provider;	01370		

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01370	Continued From page 13 - maintenance of a clean and safe environment; - hair care and bathing; - care of teeth, gums, and oral prosthetic devices; - care and use of hearing aids; - dressing and assisting with toileting; - standby assistance techniques and how to perform them; - medication, exercise, and treatment reminders; - 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; - awareness of commonly used health technology equipment and assistive devices. ULP-D ULP-D started employment and began providing assisted living services on February 1, 2022. On July 11, 2022, at 12:29 p.m., ULP-D was observed administering eye drops to R1. ULP-E ULP-E started employment and began providing assisted living services on September 24, 2021. On July 12, 2022, at 11:34 a.m., ULP-E was observed administering insulin to R4. ULP-D and ULP-E's employee record contained transcripts of courses completed but lacked evidence of completion of the above required training. On July 13, 2022, at 2:43 p.m., registered nurse (RN)-B stated staff train each other and she does not do competency of staff other than with medications. RN-B further indicated she did not know training and competencies needed to be completed on all the required topics, and verified	01370		

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01370	Continued From page 14 the above topics were lacking from ULP-D and ULP-E's employee file. RN-B indicated employees hired in the last couple of years would potentially be lacking the required competencies. The licensee's Assisted Living Orientation - ULP Staff policy dated August 1, 2021, noted training and competency evaluations of unlicensed personnel providing assisted living services will be completed by a registered nurse. In addition to training all staff receive, ULPs who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test: -changes of condition i. observation ii. how and where to report -maintenance of a clean and safe environment - communication skills including i. preserving dignity of the resident ii. showing respect for the resident, resident preferences, cultural background, and family -commonly used health technology equipment and assistive devices Additional training on the following topics with a written or oral competency test and a skill demonstration: -hair care -bathing -care of teeth, gums, and oral prosthetic devices -care and use of hearing aids -dressing -assisting with toileting -standby assistance techniques -medication reminders -exercise reminders -treatment reminders No further information was provided.	01370		

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01370	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=E	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: (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 observation, interview and record review, the licensee failed to ensure training and competency evaluations contained all the required training prior to providing direct care for two of two unlicensed personnel (ULP-D, ULP-E) 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 a pattern scope (when more than a	01380		

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01380	Continued From page 16 limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-D and ULP-E's employee record lacked evidence to indicate the employee's completed training and/or practical skills evaluations as required in the following areas prior to providing direct care services: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; - reading and recording temperature, pulse, and respirations of the client; - recognizing physical, emotional, cognitive, and developmental needs of the client; - safe transfer techniques and ambulation; - range of motioning and positioning. ULP-D started employment and began providing assisted living services on February 1, 2022. On July 11, 2022, at 12:29 p.m., ULP-D was observed administering eye drops to R1. ULP-E started employment and began providing assisted living services on September 24, 2021. On July 12, 2022, at 11:34 a.m.. ULP-E was observed administering insulin to R4. ULP-D and ULP-E's employee record contained a transcript which listed various training topics; however, the transcript lacked evidence of the above required topics.	01380		

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01380	Continued From page 17 On July 13, 2022, at 2:43 p.m.. registered nurse (RN)-B stated staff train each other and she does not do competency of staff other than with medications. RN-B further indicated she did not know training and competencies needed to be completed on all the required topics, and verified the above topics were lacking from ULP-D and ULP-E's employee file. RN-B indicated employees hired in the last couple of years would potentially be lacking the required competencies. The licensee's Assisted Living Orientation - ULP Staff policy dated August 1, 2021, noted training and competency evaluations of unlicensed personnel providing assisted living services will be completed by a registered nurse. In addition to training all staff receive, ULPs who are not a registered nursing assistant will receive additional training on the following topics with a written or oral competency test: -basic knowledge of i. body functioning ii. changes in body functioning iii. injuries or other observed changes that must be reported to appropriate personnel -recognizing physical, emotional, cognitive and developmental needs of the resident Additional training on the following topics with a written or oral competency test and a skill demonstration: - safe transfer techniques and ambulation - range of motion -positioning No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		

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01440	Continued From page 18	01440		
01440 SS=E	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for two of two unlicensed personnel (ULP-D, ULP-E) 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	01440		

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01440	Continued From page 19 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 11, 2022, at 12:29 p.m., ULP-D was observed administering eye drops to R1. ULP-D was hired on February 1, 2022, to provide direct care services to residents at the assisted living. ULP-D's employee record lacked documentation of a registered nurse (RN) supervising ULP-D performing delegated tasks within 30 days of beginning work with the licensee. On July 12, 2022, at 11:34 a.m., ULP-E was observed to administer insulin to R4. ULP-E was hired on September 24, 2021, to provide direct care services to residents at the assisted living. ULP-E's employee record lacked documentation of a RN supervising ULP-D performing delegated tasks within 30 days of beginning work with the licensee. On July 13, 2022, at 2:43 p.m., RN-B confirmed ULP-D and ULP-E's employee file lacked a 30-day supervision of delegated tasks. RN-B indicated she was not aware of the requirement. The licensee's Supervision of Unlicensed Personnel policy dated August 1, 2021, noted direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or	01440		

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01440	Continued From page 20 assigned therapy tasks must be performed within 30 days after the person begins work for our facility and has been trained and determined competent to perform all the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01440		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced	01620		

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01620	Continued From page 21 by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment for two of two residents (R1, R2) 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1's and R2's record lacked evidence the RN conducted a reassessment no more than 90 calendar days from the date of the last assessment. R1 R1's Service Plan (Private) - Addendum to Contract unsigned, with an effective date of July 1, 2022, indicated R1 received services that included thromboembolism-deterrent (TED) hose (support stockings to prevent blood clots) application and removal, ambulation in hallway, bathing assistance, and medication administration. R1's last three assessments were requested. Assessments dated August 17, 2021, February 25, 2022, and June 14, 2022, were provided. The February 25, 2022, assessment was 192 days from the last date of the assessment. The June	01620		

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01620	Continued From page 22 14, 2022, assessment was 109 days from the last date of the assessment, exceeding 90 calendar days. R2 R2's Service Plan (Private) - Addendum to Contract unsigned, with an effective date of July 11, 2022, indicated R2 received services that included assistance with bathing, dressing, and medication administration. R2's last two assessments were requested. Assessments dated August 17, 2021, and June 17, 2022, were provided. The June 17, 2022, assessment was 304 days from the last date of the assessment, exceeding 90 calendar days. On July 13, 2022, at 9:15 a.m., RN-B verified both R1 and R2's assessments were greater than 90 days apart. RN-B stated she had gotten behind in completion of the assessments because she had been working a lot on the floor to help with staffing. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated August 1, 2021, indicated the RN would complete a comprehensive nursing assessment of the resident's physical, mental, and cognitive needs periodically but no less than every 90-days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 23 (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 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	01730		

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01730	Continued From page 24 professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the medication management plan had all required content two of two residents (R1, R2) who received medication management services 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on July 11, 2022, at approximately 11:00 a.m., registered nurse (RN)-B stated the licensee provided medication management services to the licensee's residents. R1 and R2's individual medication management plans lacked: -a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; -documentation of specific resident instructions relating to the administration of medications; -identification of medication management tasks that may be delegated to unlicensed personnel;	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30285	A. BUILDING: _____ B. WING _____	07/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRUMAN MANOR APARTMENTS	402 NORTH 4TH AVENUE EAST TRUMAN, MN 56088

(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 25 -procedures for staff notifying a RN or appropriate licensed health professional when a problem arises with medication management services; and -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. R1 R1's Service Plan (Private) - Addendum to Contract unsigned, with an effective date of July 1, 2022, indicated R1 received services that included medication administration. R1's prescriber's orders, dated June 10, 2022, included three eye drops for glaucoma, one medication for memory, one anti-depressant, five supplements, one diuretic, and one hormone for thyroid. On July 11, 2022, at 12:29 p.m., ULP-D was observed administering eye drops to R1. R1's medication management plan lacked the content described above. R2 R2's Service Plan (Private) - Addendum to Contract unsigned, with an effective date of July 11, 2022, indicated R2 received services that included medication administration. R2's prescriber orders dated April 22, 2022, included two mild pain medications, one diuretic, three to lower blood pressure, one for allergies, three supplements, one for incontinence, and one for reflux.	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01730	Continued From page 26 On July 13, 2022, at 8:25 a.m., ULP-E was observed to administer medications to R2. R2's medication management plan lacked the content described above. On July 13, 2022, at 9:15 a.m., vice president of assisted living (VP)-G verified the resident's medication management plans lacked the above required content. VP-G stated every item that has a "star" in the assessment should be addressed to meet the required components. RN-B stated she was not aware of the requirement, stating she was not sure if she had addressed the required areas of the assessment to meet the requirement for other residents receiving medication management. The licensee's 7.01 Medication Management - Assessment, Monitoring & Reassessment policy dated December 21, 2021, noted a registered nurse, licensed health professional, or authorized prescriber would conduct an assessment to determine what medication management services would be provided and how the services would be provided. The policy did not include direction for development of the individualized medication management plan. No further information was provided. 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,	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30285	A. BUILDING: _____ B. WING _____	07/13/2022

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01770	Continued From page 27 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 interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R1, R5) 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 the residents). The findings include: During the entrance conference on July 11, 2022, at approximately 11:00 a.m., registered nurse (RN)-B confirmed the licensee provided medication management services to the licensee's residents, including medication setup. R1 R1's Service Plan (Private) - Addendum to Contract unsigned, with an effective date of July 1, 2022, indicated R1 received services that included medication administration. R1's clinical update assessment dated June 14, 2022, identified R1 needed full medication management and set up of medications.	01770		

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	30285	A. BUILDING: _____ B. WING _____	07/13/2022

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01770	Continued From page 28 R1's prescriber orders dated June 10, 2022, included the following orders: Fish Oil (supplement) 1000 milligrams (mg) by mouth once daily in med minder (a pillbox that has medications arranged by time of day); furosemide (for fluid management) 20 mg by mouth once daily in med minder until card comes- take 1/2 tablet; One a Day (supplement) one tablet by mouth every morning in med minder; Super B Complex (supplement) one caplet by mouth every morning in med minder; and Vitamin D3 50 micrograms (mcg) by mouth once daily in med minder. R5 R5's Service Plan - Waiver unsigned, with effective date of July 13, 2022, noted services including medication administration. R5's prescriber orders dated April 22, 2022, included the following orders: calcium/D3 tab (health maintenance) 600-10 mg by mouth once daily in med minder and Vitamin D3 cap (health maintenance) 2000 unit by mouth once daily in med minder. On July 12, 2022, at 12:20 p.m., ULP-E was observed to administer medications to R5. Some medications were on cards in the medication cart and other medications were identified to be in the med minder per the electronic medication administration record (eMAR). R1 and R5's record lacked documentation by the licensed nurse at the time of setup to include the name of medication, quantity of dose, times to be administered, and route of administration. On July 13, 2022, at 10:50 a.m., registered nurse (RN)-B stated she did not document that a	01770		

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	30285	A. BUILDING: _____ B. WING _____	07/13/2022

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01770	Continued From page 29 medication setup had been completed, or what medications, quantity of dose, times, or route. RN-B indicated she had been setting up bulk medications and alerts staff on the eMAR if there are medications in a med minder. RN-B further stated this was the process used for all medication set ups and was not aware of this requirement until recently from a sister facility. The licensee's 7.09 Medication Management - Dosage Box Setup policy dated December 28, 2021, noted a licensed nurse would assure the medication orders were transcribed onto the medication administration record (MAR). The profile would include: a. dates of medication set up b. medication name c. quantity of dose d. times to be administered e. route of administration f. name of the person completing the medication setup g. visual description of medication h. drug classification and special precautions No further information was provided. TIME PERIOD TO CORRECT: Seven (7) Days	01770		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30285	A. BUILDING: _____ B. WING _____	07/13/2022

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02310	Continued From page 30 Based on observation, interview and record review, the licensee failed to ensure the care and services were provided according to acceptable health care, medical or nursing standards for one of one resident (R2) with a side rail. This resulted in an immediate correction order on July 11, 2022, at 5:20 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 11, 2022, at 1:58 p.m., the surveyor observed a bedrail on the left side of R2's twin sized bed. The rail had a mesh covering, was secured to the bed frame but wiggled when grabbed by surveyor. It was approximately 3 feet long and 1 foot tall and had straps laying on the floor underneath the bed frame. A rectangular "U" shaped side rail was located on the right side near the head of R2's bed. The grab bar was secured to the bed frame. R2 stated she used the grab bar for transfers in and out of bed and liked the longer rail on the left side of her bed because she could feel when she was getting near the edge of the bed. R2 further stated her family had purchased and installed the bedrails. R2's diagnoses included congestive heart failure (affects pumping action of heart) bilateral macular degeneration (vision impairment), glaucoma (eye disease causing blindness), and muscle	02310		

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02310	Continued From page 31 weakness. R2's unsigned Service Plan printed July 11, 2022, indicated R2 received services which included medication administration, dressing, thromboembolism-deterrent (TED) hose (support stockings to prevent blood clots) application and removal, bathing, laundry, and housekeeping. R2's assessment dated June 17, 2022, identified R2 was independent with transfers, toileting, and bed mobility using handrails on bedside. R2's assessment further indicated R2 had been educated and provided the risks of the side rails. On July 11, 2022, at 2:51 p.m., registered nurse (RN)-B stated she did not know the manufacturer or have the manufacturer instructions for the bedrails. RN-B confirmed she would not have a way of knowing if the bedrail had been recalled, installed correctly, or of any limitations or safety considerations without them. RN-B further verified they did not have a process for assessing the safety considerations of consumer purchased side rails. The licensee's Assessing the Safety of Side Rails policy dated January 2016, noted the RN would assess and evaluate what the resident's needs are and assess to determine if the resident can safely utilize the side rail/equipment. If the RN determines that the resident is not able to safely use a side rail, or that the side rail does not meet the Food and Drug Administration (FDA) or most current safety guidelines, the RN will recommend that the side rail be removed and will document this recommendation, will document to whom the education was directed and will document the person who was given the recommendation to remove the side rail.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 32 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On July 12, 2022, at 2:32 p.m. the immediacy of correction order 2310 was removed; however, non-compliance remains at a scope and level of I. TIME PERIOD FOR CORRECTION: Two (2) Days	02310		

Minnesota Dept. of Health

Mankato

Type: Full
Date: *07/11/22*
Time: 11:45:36
Report: 1028221124

Food and Beverage Establishment Inspection Report

Location:
Truman Manor Apartments
402 North 4th Avenue East
Truman, MN56088
Martin County, 46

Establishment Info:
ID #: 0038338
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5077768706
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.

3-400A Destroying Organisims: cooking time/temperature, freezing

3-401.11A3 ** Priority 1 **

MN Rule 4626.0340A3 Cook poultry, baluts, wild animals,stuffed fish, stuffed meat, stuffed pasta, stuffed poultry, or stuffing containing fish, meat, poultry, or ratites to 165 degrees F (74 degrees C) or above for 15 seconds.

Ensure that all food items, including chicken, are being cooked to the correct temperature. Complaints were made to me about undercooked chicken being served to the residents.

Comply By: 07/20/22

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Discontinue serving leftovers at this establishment in order to come into compliance with MN Rule 4626.0506G. If leftovers are going to continue to be served, equipment must be replaced with commercial NSF-equivalent equipment.

Comply By: 07/20/22

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

Provide a temperature measuring device in the inside of the refrigerator.

Type: Full
Date: *07/11/22*
Time: 11:45:36
Report: 1028221124
Truman Manor Apartments

Food and Beverage Establishment Inspection Report

Comply By: 07/20/22

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

Provide a handwashing poster at the handwashing sinks in the kitchen and the Women's restroom.

Comply By: 07/20/22

Food and Equipment Temperatures

Process/Item: Upright Freezer
Temperature: 0 Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: Egg Salad
Violation Issued: No

Process/Item: Hot Holding
Temperature: 145 Degrees Fahrenheit - Location: Peas
Violation Issued: No

Process/Item: Hot Holding
Temperature: 150 Degrees Fahrenheit - Location: Pork
Violation Issued: No

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

This Inspection was conducted in conjunction with HRD.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Dept. of Health inspection report number 1028221124 of 07/11/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Chris Knoll
Director

Signed:_____
Ryan Miller
Environmental Health Spec. II
Mankato
Ryan.Miller@state.mn.us