Electronically Delivered

November 5, 2024

Licensee
Comfort Living
2504 16th Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL36298015

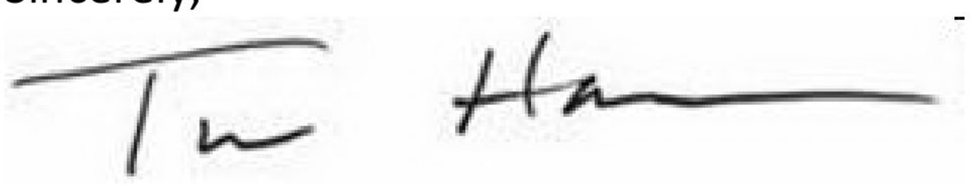
Dear Licensee:

On October 9, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 30, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD

Electronically Delivered

September 12, 2024

Licensee
Comfort Living
2504 16th Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL36298015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 30, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36298	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT LIVING	2504 16TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36298015-0 On July 29, 2024, through July 30, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two resident(s); both of whom were receiving services under the provider's provisional Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480 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: (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 documents titled, Food and Beverage Establishment Inspection Reports (FBEIR) dated July 29, 2024, and August 2, 2024, for the specific Minnesota Food Code violations. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information:	0 650		

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0 650	Continued From page 2 (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records contained all required content for three of three employees (clinical nurse supervisor (CNS)-A, unlicensed personnel (ULP)-D, and ULP-E). 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:	0 650		

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0 650	Continued From page 3 COMPETENCY EVALUATION ULP-D ULP-D was hired April 22, 2022, to provide direct care services. ULP-D's record included documentation of initial caregiver training and competency, and training and competency evaluation on all treatments, but lacked documentation of medication administration training and competency evaluation. On July 29, at 7:01 a.m., the surveyor observed ULP-D administer medications to R2. ULP-D stated he had medication administration training by the previous registered nurse (RN), when he was hired. On July 30, 2024, at 2:47 p.m., housing manager (HM)-B stated he was certain ULP-D had training on medication administration, and that the previous RN did the training with him, but did not know why it was not present in his record. HM-B stated ULP-D recently had a refresher of medication administration training through EduCare (online training program). ULP-E ULP-E was hired May 27, 2023, and provided direct care services. ULP-E's record included initial medication administration training and competency evaluation dated May 27, 2023, but the documentation lacked a signature by the RN verifying competency. The record also included documentation of additional training in medication administration and insulin administration, completed through EduCare June 12, 2024, and June 14, 2024, respectively.	0 650		

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0 650	Continued From page 4 On July 29, 2024, at 2:30 p.m., licensed assisted living director (LALD)-C stated she, CNS-A, and HM-B were responsible to ensure training was completed. LALD-C further stated CNS-A would have been the one that provided initial training and competency evaluation for ULP-E. On July 30, 2024, at 12:47 p.m., CNS-A stated he was responsible for making sure ULP-E was trained and competency tested in medication administration, and was not sure why he did not sign the documents. CNS-A further stated ULP-D almost always performed the blood sugar testing and medication administration, but ULP-E could also do it, if needed. PERFORMANCE EVALUATIONS CNS-A was hired December 1, 2022, to provide supervisory and direct care services for the licensee. CNS-A, ULP-D, and ULP-E's employee records lacked an annual performance review that identified areas of improvement and training needs. On July 29, 2024, at 1:45 p.m., HM-B stated they likely did not have any documented performance review for CNS-A. HM-B further stated it would be the job of LALD-C to do annual performance reviews, including CNS-A, but probably was not on her radar because they were "more like equals". HM-B stated he could do the performance review for CNS-A, if necessary. On July 30, 2024, at 12:37 p.m., CNS-A stated he had not had a performance review since he started working for the licensee, and had not done a performance review for ULP-D recently,	0 650		

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0 650	Continued From page 5 that he remembered. The licensee's Personnel Records policy, dated August 1, 2021, indicated, "At a minimum, all documents related to the following are kept in the personnel record, as applicable to job requirements: -Evidence of current professional licensure, registration or certification -Results of background studies -Records of annual training and infection control training -Documentation of orientation -Documentation of supervision, as applicable -Performance reviews -Competency evaluations -Signed job description -Documentation of annual performance reviews identifying areas of improvement needed and training needs". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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 6 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 that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 30, 2024, from approximately 9:30 a.m. to 11:00 a.m., survey staff toured the facility with owner and housing manager (HM)-B. Survey staff	0 780		

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0 780	Continued From page 7 asked HM-B to initiate a test of the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the facility were not interconnected. On July 30, 2024, at 11:30 a.m., HM-B stated they understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 800		

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0 800	Continued From page 8 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 30, 2024, from approximately 9:30 a.m. to 11:00 a.m., survey staff toured the facility with owner and housing manager (HM)-B. The following was observed: GENERAL MAINTENANCE: The sink in the half bath adjacent to the kitchen had sealant that was cracked, broken, or missing in some areas with dark staining as a possible indication of mold growth along the entire joint where the sink met the wall. The wall behind the vanity in the half bath adjacent to the kitchen had a large hole, approximately 10 inches high by 8 inches wide, where the plumbing and the wall cavity were exposed to the damp environment of the bathroom. On July 30, 2024, at 11:30 a.m., HM-B stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) 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	0 810		

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0 810	Continued From page 9 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 10 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 30, 2024, from approximately 9:30 a.m. to 11:00 a.m., survey staff observed the fire evacuation diagrams did not include the room numbers associated with each bedroom. Exit plan diagrams must be correctly labeled to reduce confusion and potential obstructions to egress in a fire or similar emergency. On July 30, 2024, licensed assisted living director (LALD)-C and owner and housing manager (HM)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", undated, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection	0 810		

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0 810	Continued From page 11 actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. On July 30, 2024, at 11:30 a.m., LALD-C stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-C lacked documentation showing any training was completed or training was scheduled for a future date for staff on the fire safety and evacuation plan. On July 30, 2024, at 11:30 a.m., LALD-C stated they understood the requirements for training	0 810		

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	36298	A. BUILDING: _____ B. WING _____	07/30/2024

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COMFORT LIVING	2504 16TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 12 residents and staff and would implement a training program that was compliant with statute requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 820 SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some 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	0 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 820	Continued From page 13 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: On July 30, 2024, from approximately 9:30 a.m. to 11:00 a.m., survey staff toured the facility with owner and housing manager (HM)-B. During the tour, survey staff asked HM-B to open the windows in the resident bedrooms for measurement. The noncompliant measurements were as follows: UNOCCUPIED SLEEPING ROOMS: Bedroom 2: One window measuring 24 3/4 inches clear width, 25 1/2 inches clear height, and 631 square inches total open area. The window in bedrooms 1 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to HM-B that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On July 30, 2024, HM-B stated they understood the requirements for egress windows and would start the process of getting the windows replaced.	0 820		

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0 820	Continued From page 14 TIME PERIOD FOR CORRECTION: Seven (7) days	0 820		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R2). This had the potential to affect all current 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	0 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 930	Continued From page 15 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: R2's diagnoses included diabetes, schizoaffective disorder, anxiety, and insomnia. R2's Service Plan dated July 19, 2024, indicated R2 received services including assistance with bathing reminders, dressing, grooming, housekeeping, laundry, behavior management, blood glucose monitoring, and medication management. R2's Assisted Living Contract signed on August 13, 2021, lacked the following required content: - the right under section 144G.54 to appeal the termination of an assisted living contract. On July 30, 2024, at 11:20 a.m., owner and housing manager (HM)-B stated he bought the contract forms and so thought they would meet requirements. HM-B further stated all residents receive the same contract, and they "will need to get that fixed". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 930		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility	0 950		

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0 950	Continued From page 16 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 licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for one of one resident (R2). 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	0 950		

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0 950	Continued From page 17 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: R2's diagnoses included diabetes, schizoaffective disorder, anxiety, and insomnia. R2's Service Plan dated July 19, 2024, indicated R2 received services including assistance with bathing reminders, dressing, grooming, housekeeping, laundry, behavior management, blood glucose monitoring, and medication management. R2's Assisted Living Contract signed on August 13, 2021, did not include an opportunity to identify a designated representative, and lacked the verbatim notice of the right to designate a representative on a page separate from the contract. On July 30, 2024, at 11:20 a.m., owner and housing manager (HM)-B stated he bought the contract forms and so thought they would meet requirements and did not realize they were missing the "right to designate" information. HM-B further stated all residents receive the same contract, and they "will need to get that fixed". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		

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0 970	Continued From page 18	0 970		
0 970 SS=C	144G.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 facility's liability for health, safety, or personal property of a resident. 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: R2's diagnoses included diabetes, schizoaffective disorder, anxiety, and insomnia. R2's Service Plan dated July 19, 2024, indicated R2 received services including assistance with bathing reminders, dressing, grooming, housekeeping, laundry, behavior management, blood glucose monitoring, and medication	0 970		

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0 970	Continued From page 19 management. R2's Assisted Living Contract signed on August 13, 2021, included the following language, indicating a waiver of liability: "Miscellaneous Provisions 1. Insurance Liability and Release: The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee] upon request. The resident acknowledges that [licensee] is not an insurer of the resident's person or property. The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents. The resident hereby releases [licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [licensee] or its employees or agents. 4. Premises Deemed Uninhabitable: If the property is deemed uninhabitable due to damage beyond reasonable repair, the resident will be able to terminate this Contract by written notice to [licensee]. If said damage was due to the negligence of the resident, the resident shall be liable to [licensee] for all repairs and for the loss of income due to restoring the premises back to a livable condition in addition to any other losses that can be proved by [licensee]."	0 970		

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0 970	Continued From page 20 On July 30, 2024, at 11:20 a.m., owner and housing manager (HM)-B stated he bought the contract forms and so thought they would meet requirements and did not realize the waiver statements were not allowed. HM-B further stated all residents receive the same contract, and they "will need to get that fixed". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
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;	01370		

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01370	Continued From page 21 (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 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 was completed with all required content for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired was hired on May 27, 2023, to provide direct care services to residents of the assisted living facility. ULP-E's employee record lacked documentation	01370		

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01370	Continued From page 22 of training and competency evaluations for ULP providing assisted living services including: -appropriate and safe techniques in personal hygiene and grooming, including: - 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; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; and -awareness of commonly used health technology equipment and assistive devices. On July 29, 2024, at approximately 10:30 a.m., during the entrance conference, owner and housing manager (HM)-B stated initial competency training was provided through Educare (an online training program) and the registered nurse (RN) would assess competency. On July 29, 2024, at 2:30 p.m., licensed assisted living director (LALD)-C stated she, clinical nursing supervisor (CNS)-A, and HM-B would be responsible to make sure all caregiver training was completed. Stated CNS-A would have been the one that did her initial training and competency. The licensee's Staff Competency policy, dated August 1, 2021, indicated, "Training and competency evaluations for all unlicensed personnel include the following. Refer to the Competency Manual for criteria. Unlicensed personnel may not work for [licensee] until they	01370		

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01370	Continued From page 23 have successfully passed the written (at 80%) and demonstration competency evaluation. a. Documentation requirements for all services provided b. Reports of changes in the resident's condition to the supervisor designated by the home care provider c. Basic infection control, including blood-borne pathogens d. Maintenance of a clean and safe environment e. Appropriate and safe techniques in personal 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 f. Training on the prevention of falls for providers working with the elderly or those at risk of falls g. Standby assistance techniques and how to perform them h. Medication, exercise and treatment reminders i. Basic nutrition, meal preparation and preparation of modified diets as ordered by a licensed health professional, food safety and assistance with eating j. 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 k. Awareness of confidentiality and privacy l. Understanding appropriate boundaries between staff, residents and the residents' family m. Procedures to utilize in handling various emergency situations n. Awareness of commonly used health technology equipment and assistive devices." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		

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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: (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 evaluation was completed with all required content for one of two employees (unlicensed personnel (ULP)-E). 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:	01380		

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01380	Continued From page 25 ULP-E was hired was hired on May 27, 2023, to provide direct care services to residents of the assisted living facility. ULP-E's employee record lacked documentation of training and competency evaluations for ULP providing assisted living services including: -observation, reporting, and documenting of resident status; -reading and recording temperature, pulse, and respirations of the resident; -safe transfer techniques and ambulation; and -range of motioning and positioning. On July 29, 2024, at approximately 10:30 a.m., during the entrance conference, owner and housing manager (HM)-B stated initial competency training was provided through Educare (an online training program) and the registered nurse (RN) would assess competency. On July 29, 2024, at 2:30 p.m., licensed assisted living director (LALD)-C stated she, clinical nursing supervisor (CNS)-A, and HM-B would be responsible to make sure all caregiver training was completed. Stated CNS-A would have been the one that did her initial training and competency. The licensee's Staff Competency policy, dated August 1, 2021, indicated, "Home Health Aides may not work for [licensee] until they have successfully passed the written and demonstration competency evaluation, including satisfactory completion of the following: i. Observation, reporting and documenting of resident status ii. Basic knowledge of body functioning and changes in body function, injuries or other	01380		

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01380	Continued From page 26 reportable changes iii. Recognizing physical, emotional, cognitive and development needs of the resident iv. Basic infection control, including blood-borne pathogens v. Maintenance of a clean and safe environment vi. Falls prevention vii. Safe transfer techniques and ambulation viii. Range of motion and positioning ix. Administering medications or treatments as required x. Basic nutrition, meal preparation, food safety and assistance with eating xi. Preparation of modified diets xii. Communication skills and barriers xiii. Cultural diversity xiv. Confidentiality/privacy xv. Professional boundaries xvi. Handling of emergencies xvii. Commonly used health technology equipment and assistive devices". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=D	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	01440		

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	36298	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT LIVING	2504 16TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01440	Continued From page 27 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 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 one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-E was hired was hired on May 27, 2023, to provide direct care services to residents of the assisted living facility.	01440		

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01440	Continued From page 28 ULP-E's employee record lacked documentation of 30-day supervision of delegated nursing tasks. On July 29, 2024, at approximately 10:30 a.m., during the entrance conference, owner and housing manager (HM)-B stated initial competency training was provided through Educare (an online training program) and the RN would assess competency. On July 29, 2024, at 2:30 p.m., licensed assisted living director (LALD)-C stated she, clinical nursing supervisor (CNS)-A, and HM-B would be responsible to make sure all caregiver training was completed. LALD-C stated she did not know what the 30-day supervision was, or whether it had been completed for ULP-E. LALD-C stated CNS-A would have done initial training and competency for ULP-E. On July 30, 2024, at 12:47 p.m., CNS-A stated he had observed ULP-E, but had not documented the observations. The licensee's Supervision: Unlicensed Staff policy, dated August 1, 2021, indicated, "Direct supervision of home health aides performing delegated tasks will be provided within 30 days after the individual begins working for the assisted living provider and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01500 SS=D	144G.63 Subd. 5 Required annual training	01500		

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01500	Continued From page 29 (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research	01500		

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01500	Continued From page 30 based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received at least eight (8) hours of annual training for each 12 months of employment for one of two employees (clinical nursing supervisor (CNS)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: CNS-A was hired December 1, 2022, to provide supervisory and direct care services in the assisted living facility.	01500		

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01500	Continued From page 31 CNS-A's employee record lacked documentation of eight hours of annual training completed within the last 12 months, including the following required topics: - A review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; - Effective approaches to use to problems solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. On July 29, 2024, at 1:36 p.m., owner and housing manager (HM)-B stated they did not have any additional annual training documented for CNS-A. HM-B stated he expected CNS-A would monitor their own education requirements, and it was missed because he was assuming CNS-A would be responsible for it. The licensee's Staff Orientation and Education policy, dated August 1, 2021, indicated, "All staff providing assisted living services will complete at least eight (8) hours of education for every twelve (12) months of employment." and, "Education topics will include, but not be limited to, the following a. Reporting of maltreatment of adults b. Review of Assisted Living Bill of Rights and staff responsibilities related to ensuring the exercise and protection of those rights c. Review of the organization's policies and procedures related to provision of assisted living	01500		

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01500	Continued From page 32 services and how to implement them d. Infection control techniques used in the home i. Implementation of infection control standards based on current recommendations per the CDC ii. Hand washing techniques iii. Need for/use of personal protective equipment (PPE), including: 1. Gloves 2. Gowns 3. Masks iv. Appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes and razor blades v. Disinfection of reusable equipment vi. Disinfection of environmental surfaces vii. Reporting of communicable diseases e. Effective approaches to use to problem solve when working with a resident's challenging behaviors and how to communicate with residents who have dementia, Alzheimer's Disease or related disorders f. The principles of person-centered planning and service delivery and how they apply to direct support services provided by staff." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working	01530		

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01530	Continued From page 33 hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the required amount of dementia care training was completed in the required time frame in accordance with 144G.64 for three of three employees, (clinical nursing supervisor (CNS)-A, unlicensed personnel (ULP)-D, and ULP-E). 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).	01530		

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01530	Continued From page 34 The findings include: CNS-A was hired December 1, 2022, to provide supervisory and direct care services in the assisted living facility. CNS-A's employee record lacked evidence of eight hours of dementia care training completed within 120 hours of the employment start date. CNS-A's record further lacked evidence of at least two hours of ongoing dementia care education completed annually. ULP-D and ULP-E were hired April 22, 2022, and May 27, 2023, respectively, to provide direct care services. ULP-D, and ULP-E's employee records lacked evidence of eight hours of dementia care training completed within 160 hours of the employment start date. On July 29, 2024, at 1:36 p.m., owner and housing manager (HM)-B stated they did not have any additional annual training documented for CNS-A. HM-B stated he expected CNS-A would be responsible for completing what was assigned. On July 29, 2024, at 2:30 p.m., licensed assisted living director (LALD)-C stated she, CNS-A, and HM-B would be responsible to make sure all caregiver training was completed. The licensee's Dementia Education policy, dated August 1, 2021, indicated supervisors of direct-care staff would have at least eight (8) hours of initial education within 120 working hours, and direct care employees must have	01530		

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01530	Continued From page 35 completed at least eight (8) hours of initial education within 160 working hours of the employment start date in the following topics: a. An explanation of Alzheimer's Disease and other dementias b. Assistance with activities of daily living (AOL's) c. Problem solving with challenging behaviors d. Communication skills e. Person-centered planning and service delivery The policy further indicated both supervisors and direct care employees would complete at least two (2) hours of education on topics related to dementia for each twelve (12) months of employment thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	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	01620		

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01620	Continued From page 36 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 ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, utilizing a uniform assessment tool, not to exceed 90 calendar days from the last assessment date for two of two residents (R2, R3). 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: R2 R2's diagnoses included diabetes, schizoaffective disorder, anxiety, and insomnia. R2's Service Plan dated July 19, 2024, indicated R2 received services including assistance with bathing reminders, dressing, grooming, housekeeping, laundry, behavior management, blood glucose monitoring, and medication management.	01620		

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01620	Continued From page 37 R2's record included a nursing assessment completed March 13, 2024, and a subsequent assessment completed June 12, 2024, 91 days after the previous assessment. R3 R3's diagnoses included schizophrenia, post-traumatic stress disorder, siezure disorder and traumatic brain injury. R3's Service Plan, printed July 30, 2024, indicated R3 received services including assistance with appointment reminders, bathing, dressing, grooming, housekeeping, incontinence care, laundry, behavior management, and medication management. R3's record included a nursing assessment completed March 6, 2024, and a subsequent assessment completed June 6, 2024, 92 days after the previous assessment. On July 30, 2024, at 12:47 p.m., clinical nursing supervisor (CNS)-A stated he had reminders scheduled in RTASKS (an electronic record keeping program), but realized he was completing the assessments every three months rather than every 90 days, which resulted in them going past 90 days. On July 30, 2024, at 2:47 p.m., owner and housing manager (HM)-B stated since CNS-A had reminders set up in RTASKS, they should have been completed on time. The licensee's Assessment and Reassessment policy, dated August 1, 2021, indicated, "Ongoing resident reassessments must be completed by an RN and cannot exceed 90 days from the last date	01620		

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01620	Continued From page 38 of assessment." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered per providers orders for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred	01760		

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01760	Continued From page 39 only occasionally). The findings include: R2's diagnoses included schizoaffective disorder, anxiety, and insomnia. R2's Service Plan dated July 19, 2024, indicated R2 received services including assistance with behavior management, and medication management. On July 29, at 7:01 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R2. R2's record included a prescriber order dated February 26, 2024, that indicated: - Hydroxyzine hydrochloride (HCL) 25 milligrams (mg), take one tablet twice a day as needed for anxiety or sleep. R2's medication administration record (MAR) for July 2024, indicated: - Hydroxyzine HCL 25 mg, take one tablet daily as needed for anxiety or sleep, instead of "one tablet twice a day as needed", per the signed order. Hydroxyzine appeared on the MAR, scheduled for 8:00 a.m. R2's Hydroxyzine medication bottle label indicated Hydroxyzine HCL 25 mg, take one tablet by mouth daily as needed, rather than twice a day as needed, per the signed order. On July 30, 2024, at 11:45 a.m., licensed assisted living director (LALD)-C stated she did not have any additional orders for R2, and stated the Hydroxyzine order was likely entered in the MAR incorrectly by mistake.	01760		

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01760	Continued From page 40 On July 30, 2024, at 11:55 a.m., owner and house manager (HM)-B stated that as professionals, he would expect clinical nursing supervisor (CNS)-A and LALD-C to make sure all requirements were met regarding prescription orders. On July 30, 2024, at 12:47 p.m., CNS-A stated he added changes as shown on the residents' clinic after visit summaries, and then had the provider sign the residents' medication list annually. The licensee's Medication Orders policy, dated August 1, 2021, indicated, "[Licensee] will administer medications as prescribed by the authorized prescriber and in accordance with all the rights defined in the Home Care Bill of Rights and in the Health Insurance Portability and Accountability Act." No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure written or electronically recorded prescriptions for medications were obtained for one of two	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36298	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT LIVING	2504 16TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
01820	Continued From page 41 residents (R2). 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: R2's diagnoses included diabetes, schizoaffective disorder, anxiety, and insomnia. R2's Service Plan dated July 19, 2024, indicated R2 received services including assistance with behavior management, and medication management. On July 29, at 7:01 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R2. R2's record included signed prescriber orders dated February 26, 2024, that indicated: -Farxiga (dapagliflozin, for diabetes) 5 milligrams (mg) one (1) tablet once in a.m.; -lantus (insulin glargine, for diabetes) 14 units (u) daily at bedtime; -melatonin 5 mg tablet by mouth (po) at bedtime for sleep; -nicotine gum (for smoking cessation) po as needed; and -olanzapine (antipsychotic) 15 mg, one tablet by mouth at bedtime, with a note initialed by the provider that read, "I have olanzapine 10 mg once daily at bedtime on [clinic] records. Please verify dose with psych provider."	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36298	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT LIVING	2504 16TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
01820	Continued From page 42 R2's medication administration record (MAR) for July 2024, indicated the following were administered July 1-29, 2024: -Farxiga 10 mg 1 tablet once in a.m.; -olanzapine 15 mg, "Take 1 tablet by mouth every night at bedtime". The MAR did not indicate the following medications were available, as ordered: -lantus 14 u daily at bedtime; -melatonin 5 mg tablet po at bedtime for sleep; and -nicotine gum po as needed. R2's record lacked signed prescriber orders for Farxiga 10 mg, olanzapine 15 mg, and to discontinue use of lantus, melatonin, and nicotine gum. R2's comprehensive nursing assessment, dated June 12, 2024, indicated, "Current list of medications reviewed including the reason taken, dosage, frequency of use, and route administered or taken: Meds are reviewed and appropriate for resident's use." On July 30, 2024, at 11:45 a.m., licensed assisted living director (LALD)-C stated she did not have any additional orders for R2, but that he had been to the clinic lately and the insulin order had been discontinued. LALD-C further stated the note about olanzapine should have been followed up on, and it was hard with a psychiatric provider's order, because they were very separate from the other provider, and did not always respond to requests for clarification. On July 30, 2024, at 11:55 a.m., owner and house manager (HM)-B stated he thought the insulin for R2 had been discontinued. HM-B further stated	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36298	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT LIVING	2504 16TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
01820	Continued From page 43 that as professionals, he would expect clinical nursing supervisor (CNS)-A and LALD-C to make sure all requirements were met regarding prescription orders. On July 30, 2024, at 12:47 p.m., CNS-A stated his process was to add changes into the MAR as indicated on the AVS, and then have the provider sign the resident's medication list annually. The licensee's Medication Administration policy, dated August 1, 2021, indicated, "The licensed nurse is responsible for assessing medications to assure that all medications are current and ordered by the prescriber and to identify any expired or outdated medications, which will be disposed according to policy." The licensee's Medication Orders policy, dated August 1, 2021, indicated, "[Licensee] will administer medications as prescribed by the authorized prescriber and in accordance with all the rights defined in the Home Care Bill of Rights and in the Health Insurance Portability and Accountability Act." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36298	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT LIVING	2504 16TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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01950	Continued From page 44 the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency was completed for blood glucose monitoring for one of two employees (unlicensed personnel (ULP)-E). 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: R2's diagnoses included diabetes, schizoaffective disorder, anxiety, and insomnia. R2's Service Plan dated July 19, 2024, indicated R2 received services including assistance with	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36298	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT LIVING	2504 16TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
01950	Continued From page 45 behavior management, medication management, and blood glucose monitoring "2 times per day, every 2 days". R2's record included signed prescriber orders dated February 26, 2024, that indicated blood sugar checks completed via finger stick three (3) times daily, at 8:00 a.m., 3:00 p.m., and 10:00 p.m. ULP-E was hired May 27, 2023, and provided direct care services. ULP-E's record lacked documentation of training and competency testing in performing blood glucose checks for R2. On July 29, 2024, at 2:30 p.m., licensed assisted living director(LALD)-C stated she thought ULP-E was trained on performing blood sugar testing, but could not say the date of the training. On July 30, 2024, at 12:47 p.m., clinical nursing supervisor (CNS)-A stated he was responsible for making sure ULP-E was trained and competency tested. CNS-A further stated ULP-D almost always performed the blood sugar testing, but ULP-E could also do it, if needed. The licensee's Delegation of Assisted Living Tasks policy, dated August 1, 2021, indicated, "The clinician may delegate procedures according to the following a. The clinician instructed the home health aide in the proper methods to perform the procedure with respect to each resident. b. The clinician provided the home health aide with written instructions specific to the resident. c. The home health aide demonstrated to the clinician competence in the procedure.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36298	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT LIVING	2504 16TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
01950	Continued From page 46 d. The procedure is documented in the resident's clinical record. e. The home health aide's competence is documented in his/her personnel file." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy 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 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	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36298	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT LIVING	2504 16TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
01970	Continued From page 47 situation has occurred only occasionally). The findings include: R2's diagnoses included diabetes, schizoaffective disorder, anxiety, and insomnia. R2's Service Plan dated July 19, 2024, indicated R2 received services including assistance with behavior management, medication management, and blood glucose monitoring "2 times per day, every 2 days". R2's record included signed prescriber orders dated February 26, 2024, that indicated blood sugar checks completed via finger stick three (3) times daily, at 8:00 a.m., 3:00 p.m., and 10:00 p.m. R2's diabetic flow sheet for July 2024, indicated, "please test blood sugar once daily at alternating times before breakfast and at bedtime." The flow sheet showed blood sugar readings documented once daily July1-29, 2024, with values ranging from 96-158 milligrams per deciliter. On July 30, 2024, at 12:47 p.m., clinical nursing supervisor (CNS)-A stated the blood glucose checks were changed recently, and he understood he would need to get a signed order for that as well as for the medications. The licensee's Prescriber's Orders policy, dated August 1, 2021, indicated, "Written orders from an authorized prescriber will be obtained for all medications and treatments with which the assisted living facility assists residents, including over the counter medications." No further information was provided.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36298	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT LIVING	2504 16TH AVENUE SOUTH MINNEAPOLIS, MN 55404

(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
01970	Continued From page 48 TIME PERIOD FOR CORRECTION: Seven (7) days	01970		

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

Type: Follow-Up
Date: *08/02/24*
Time: 14:14:26
Report: 1013241058

Food and Beverage Establishment Inspection Report

Location:
Comfort Living
2504 16th Avenue South
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:
ID #: 0037629
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122450495
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 previously issued on 07/29/24 have NOT been corrected.

4-300 Equipment Numbers and Capacities

4-301.12A ***** Priority 2 *****

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

THE FACILITY DOES NOT HAVE A DISH MACHINE OR A 3-COMPARTMENT SINK FOR MANUAL WARE WASHING. STAFF RINSE WARE WITH WATER AND SOAP. DISCUSSED WARE WASHING PROCEDURES WITH STAFF.

Issued on: 07/29/24 *Comply By: 11/04/24*

No NEW orders were issued during this inspection.

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

The operator sent the inspector pictures of cleaned kitchen areas.

Discussed pest control, cleaning, and food handling procedures.

Type: Follow-Up
Date: *08/02/24*
Time: 14:14:26
Report: 1013241058
Comfort Living

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1013241058 of 08/02/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Abdirizak Mohamed Adan
Operator

Signed:_____
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us

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

Type: Full
Date: *07/29/24*
Time: 13:00:00
Report: 1013241053

Food and Beverage Establishment Inspection Report

Location:
Comfort Living
2504 16th Avenue South
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:
ID #: 0037629
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122450495
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

4-702.11 ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

STAFF ARE NOT SANITIZING WARE. ONLY SOAP AND WATER ARE USED FOR WARE WASHING. COMPLY WITH ABOVE RULE. DISCUSSED WARE WASHING REQUIREMENTS WITH STAFF. A CONTAINER WITH SANITIZER MAY BE USED UNTIL THE REQUIRED EQUIPMENT IS INSTALLED.

Comply By: 07/29/24

4-300 Equipment Numbers and Capacities

4-301.12A ***** Priority 2 *****

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

THE FACILITY DOES NOT HAVE A DISH MACHINE OR A 3-COMPARTMENT SINK FOR MANUAL WARE WASHING. STAFF RINSE WARE WITH WATER AND SOAP. DISCUSSED WARE WASHING PROCEDURES WITH STAFF.

Comply By: 11/04/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

RODENT DROPPINGS WERE ON THE FLOOR IN THE DRY STORAGE ROOM AND IN THE CABINET BELOW THE KITCHEN SINK. COMPLY WITH ABOVE RULE. DISCUSSED PEST CONTROL AND CLEANING PROCEDURES WITH STAFF.

Comply By: 07/29/24

Type: Full
Date: *07/29/24*
Time: 13:00:00
Report: 1013241053
Comfort Living

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Eggs
Temperature: 41 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: No

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

The inspection was completed with the operator then reviewed with MDH Nurse Evaluator R. Anderson.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, laminate floor, painted walls, laminate counter top, and a textured ceiling.

A two basin sink is located in the kitchen. One basin is designated for hand washing.

The facility does not have a 3-compartment sink or dish machine. Discussed ware washing procedures with staff. A sanitizer bucket/container must be set up and used until the required equipment is provided.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, glove use, and food handling procedures.

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 1013241053 of 07/29/24.

Certified Food Protection Manager: Abdirizak Mohamed Adan

Certification Number: 110619 Expires: 12/11/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Abdirizak Mohamed Adan
Operator

Signed: JM
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us