Electronically Delivered

October 8, 2024

Licensee
Miles Vents Inc.
5336 Sailor Lane
Brooklyn Center, MN 55429

RE: Project Number(s) SL36925015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 29, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. 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 . . ."

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 may be 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.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 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
	36925	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILES VENTS INC	5336 SAILOR LANE BROOKLYN CENTER, MN 55429

(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: SL# 36925015-0 On August 26, 2024, through August 29, 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 four (4) residents receiving services under the provider's 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.	
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements	0 490		

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0 490	Continued From page 1 (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 490		

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0 490	Continued From page 2 On August 26, 2024, at 10:18 a.m., during the entrance conference, clinical nurse supervisor (CNS)-D and licensed assisted living director/registered nurse (LALD/RN)-A indicated they provided a daily program of social and recreational activity. They also stated they had a position posted for an activity coordinator but in the meantime, current staff were providing the activities. Some activities they provided were going out to eat and shopping. Throughout the survey, on August 26 and 27, 2024, the surveyor observed R2 frequently walking around, observing different staff members, and the surveyor. R2 frequently changed her clothing attire and walked out of the house for short periods of time. The other residents were in their rooms, smoking outside, or out with friends/family. The surveyor did not observe any type of supplies that could be used for activities such as board games or arts and crafts that were in plain view for residents to use. The surveyor observed music videos playing on the living room television, and heard similar music playing on R2's phone while she was walking around the house. The surveyor also observed ULP-B remain in the kitchen in between tasks and did not engage R2 in any activities throughout the survey. R2's Nursing Uniform Assessment Tool dated August 9, 2024, indicated R2 had a history of elopement. Under social needs, it read R2 required attention and was very social. During an interview on August 27, 2024, at 2:15 p.m., with an unidentified resident, the resident stated outings do not happen. She stated she would walk to stores on her own but said she	0 490		

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0 490	Continued From page 3 would like to go to the mall, state fair, or the arboretum. She said going out to eat occurred occasionally. During an interview on August 27, 2024, at 3:30 p.m., with another unidentified resident, the resident stated she was bored and would like to go out, as it had been a long time since she did anything with staff. She stated she wanted to do arts and crafts but said supplies were not available. The resident said when she went to the store, it was with another resident. The calendar for August 2024 included "Arts and crafts" every Monday, "Movies" every Tuesday, "Lunch Buffet" on August 7, then "Card games" the remaining Thursdays of the month, and "Shopping" every Friday. Sundays, Wednesdays, and Saturdays were left blank. On August 28, 2024, at 3:46 p.m., CNS-D stated they were doing the best they could to engage every resident. She said they take residents out to eat and that they did have arts and crafts available. The licensee's Assisted Living Contract dated 2021, read the following were included under the basic daily fee: "9. Activities: a. Activities are scheduled regularly throughout the day. This allows those residents who work to participate. b. All residents are encouraged to attend activities within the residence or community but have the freedom to control their own schedules. c. Special events are planned throughout the month." No further information was provided.	0 490		

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0 490	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program to comply with accepted health care, medical and nursing standards for infection control for restroom use by all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 510		

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0 510	Continued From page 5 The findings include: During facility tour on August 26, 2024, at 11:17 a.m., the surveyor was informed by clinical nurse supervisor (CNS)-D there were three residents that lived on the main level and one resident that lived on the lower level. It was observed this facility had two bathrooms. The surveyor observed a bathroom with a shower, toilet, and sink on the lower level of the home which had no paper towels or hand soap. CNS-D looked around including the sink cabinet and was unable to locate the missing items. CNS-D stated there was normally soap and paper towels in the bathroom. On August 26, 2024, at 12:10 p.m., the surveyor entered the upstairs bathroom which lacked hand soap, paper towels and toilet paper. The surveyor informed CNS-D, who stated the residents hoarded the toilet paper. Unlicensed personnel (ULP)-B supplied the bathroom with a bottle of soap, a roll of paper towels, and a roll of toilet paper. On August 27, 2024, at 10:19 a.m., ULP-B stated she received orientation and skills training by CNS-D. ULP-B's employee record indicated infection control training was completed on April 22, 2024. Centers for Disease Control and Prevention (CDC) had an article titled "Clinical Safety: Hand Hygiene for Healthcare Workers," dated February 27, 2024, read, "hand hygiene protects both healthcare personnel and patients. Hand hygiene means cleaning hands with soap and water or using antiseptic hand rub (hand sanitizer). The article also read hand hygiene should be	0 510		

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0 510	Continued From page 6 performed after contact with blood, body fluids, or contaminated surfaces." The licensee's Infection Control policy dated August 1, 2021, indicated the licensee would observe the recommended precautions for home care as identified by the Centers for Disease Control and Prevention (CDC). The policy also indicated hands should be washed after assisting the resident to the toilet and after using the bathroom. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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: (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	0 650		

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0 650	Continued From page 7 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 the registered nurse (RN) documented training and competencies for one of one unlicensed personnel ((ULP)-B) who would provide medications for residents with unplanned time away from home when a licensed nurse was not available. 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: ULP-B was hired on May 6, 2024, to provide direct care to licensee's residents. On August 27, 2024, at 10:19 a.m., ULP-B stated she was trained by the RN to package resident medications for unplanned times away. ULP-B stated the process was to put the medications in a small plastic bag (showed surveyor the bag) and write the resident's name and time the medications were to be given on the bag. ULP-B said no additional information would be sent with the medications.	0 650		

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0 650	Continued From page 8 ULP-B's record lacked evidence she was trained and determined to be competent to perform the delegated task for management of medications when a resident had an unplanned time away from home. On August 27, 2024, at 10:58 a.m., clinical nurse supervisor (CNS)-D stated she trained ULPs to write the name, date, and the time medications were to be given on the plastic bag, then give it to the resident. CNS-D said they did not have written procedures and were not aware of the requirement. CNS-D stated they did not document the training and competency for anyone and would need to add that to the forms they use. On August 27, 2024, at 11:15 a.m., during continuous observations, ULP-B was observed assisting multiple residents with medication administration. The licensee's Personnel Records policy dated August 1, 2021, indicated each personnel record would include documentation of orientation and competency evaluations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by	0 660		

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0 660	Continued From page 9 the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed and documented for one of two employees (clinical nurse supervisor (CNS)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The Facility TB Risk Assessment completed by LALD/RN-A on March 18, 2024, indicated the	0 660		

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0 660	Continued From page 10 facility was at a low risk for TB transmission. CNS-D was hired on February 20, 2009, to perform supervision over unlicensed personnel (ULPs) and direct cares and assessments for residents. On August 26, 2024, at 10:30 a.m. during entrance conference, licensed assisted living director/registered nurse (LALD/RN)-A and CNS-D explained that upon hire, staff would complete a TST at the main office and staff would complete the TB symptom and history screen. CNS-D's employee record contained a baseline TB screening tool for health care workers dated April 4, 2022, which included notation that CNS-D received nine (9) month treatment in 2010 and received the Bacille Calmette-Guerin (BCG), but lacked evidence of screening for active TB with either a two-step TST or blood test within 90 days of hire or medical record showing treatment was provided. On August 27, 2024, at 1:30 p.m., CNS-D stated she was working on obtaining the TB records and would go to the clinic to obtain them if necessary. On August 29, 2024, at 10:00 a.m., during exit conference, CNS-D stated she could not provide the requested TB records. The licensee's Tuberculosis Screening/Prevention policy dated February 13, 2024, read, "Employees with a documented history of prior treatment for LTBI (latent TB infection) or active TB disease do not need a TST or BAMT (blood test): -Assess for current TB symptoms. -Keep written documentation on file of a chest	0 660		

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0 660	Continued From page 11 x-ray indicating no active TB disease that is dated after the date of the initial diagnosis of LTBI or active TB disease. -Assess these employees annually for current TB symptoms. Instruct them to see medical evaluation if TB symptoms develop at any time." The licensee's Personnel Records policy dated August 1, 2021, indicated the results of required health screening and medical examinations will be maintained in a separate, private file. The CDC Tuberculosis Screening, Testing, and Treatment of U.S. Health Care Personnel dated May 17, 2019, indicated all health personnel should have a baseline screening and an individual risk assessment, which is necessary for interpreting any test result. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor;	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36925	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILES VENTS INC	5336 SAILOR LANE BROOKLYN CENTER, MN 55429

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0 680	Continued From page 12 and (5) have a written policy and procedure regarding missing 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 interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content in. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 26, 2024, at 12:20 p.m., surveyor requested the EPP, which was located on top of the medication cabinet in the kitchen which was accessible to residents, staff, and visitors. On August 26, 2024, at 2:45 p.m., licensed	0 680		

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	36925	A. BUILDING: _____ B. WING _____	08/29/2024

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0 680	Continued From page 13 assisted living director/registered nurse (LALD/RN)-A stated the licensee was still working on updating their EPP to be compliant with state requirements, did not have the emergency preparedness testing completed but did have drills completed. She also did not have a policy/procedure to handle medical documents and other resident information. LALD/RN-A provided a blank tracking form they recently created to include resident names, staff names, date, time, and three addresses to pick from. LALD/RN-A stated they don't utilize volunteers. The licensee's EPP last reviewed/updated on February 21, 2024, lacked the following required content: -develop and maintain the EPP: -risk assessment should consider all hazards; - subsistence needs for staff and patients; - procedures for tracking of staff and patients: -develop P/P for system to track the location of on-duty staff and sheltered residents; - policies and procedures for medical documents; - policies and procedures for volunteers: -P/P must address: use of volunteers, including the process/role for integration; - roles under a waiver declared by secretary; and - emergency prep testing requirements. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupted services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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	36925	A. BUILDING: _____ B. WING _____	08/29/2024

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01530 SS=D	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 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 one of two employees (unlicensed personnel (ULP)-B) received the required dementia care training. 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	01530		

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01530	Continued From page 15 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on May 5, 2024, to provide direct services to the licensee's residents. ULP-B's record included a transcript of courses completed on an electronic training program (Educare) that indicated ULP-B received 1.75 hours of dementia training on April 2-3, 2024. ULP-B's record lacked evidence the required 8 hours of dementia care training were completed within 160 hours of working. On August 27, 2024, at 10:19 a.m., ULP-B stated she received training by clinical nurse supervisor (CNS)-D at the facility, which included orientation to assisted living statutes, resident's bill of rights, medication administration, and skills/tasks. ULP-B stated she did not receive dementia training by CNS-D but did complete dementia training courses online. On August 27, 2024, at 1:12 p.m., the surveyor received an email from the office assistant (OA) indicating ULP-B had completed 160 hours of work as of June 28, 2024. On August 27, 2024, at 2:00 p.m., CNS-D stated ULP-B's Educare transcript came from her previous job unrelated to the licensee and did not complete any dementia training with this licensee. CNS-D stated ULP-B did not complete the required eight (8) hours of dementia training.	01530		

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	36925	A. BUILDING: _____ B. WING _____	08/29/2024

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01530	Continued From page 16 The licensee's Dementia Education policy dated August 21, 2021, indicated: "3. Direct care employees must have 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 (ADL's) c. Problem solving with challenging behaviors d. Communication skills e. Person-centered planning and service delivery." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the	01560		

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	36925	A. BUILDING: _____ B. WING _____	08/29/2024

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01560	Continued From page 17 training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who requested it, the dementia care training program with the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee provided services under an Assisted Living license. On August 27, 2024, at 9:17 a.m., the surveyor requested the written or electronic form of the licensee's dementia care training program. Licensed assisted living director and registered nurse (LALD/RN)-A stated they were cited on this issue during a previous survey (another facility) and they did not have one completed yet. R2's Service Plan signed March 22, 2023, included the following, "I have received a copy of: I understand that a Dementia Notice is available," with "N/A" written next to the statement.	01560		

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	36925	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01560	Continued From page 18 The licensee's Notifications policy dated August 1, 2021, read, "Information regarding the training program for services to residents with dementia will be available to residents, families, and others who request it. a. Information may be provided in written or electronic form. b. Included will be categories of employees trained, the frequency of the training and the basic topics covered." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01560		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.	01640		

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01640	Continued From page 19 (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident's (R2) service plan were revised to include current needs based on the nursing assessment. 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 type 2 diabetes mellitus, personality disorder, post-traumatic stress disorder (PTSD), and developmental disability. R2's Service Plan signed on March 22, 2024, indicated R2 received services including assistance with behavior management, daily blood pressure, blood glucose monitoring as needed (PRN), medication administration, and supervision/cueing with dressing and grooming. The licensee's resident roster, dated May 13, 2024, indicated none of the residents received assistance with treatments or therapies. On August 26, 2024, at 10:18 a.m., during the entrance conference, licensed assisted living	01640		

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	36925	A. BUILDING: _____ B. WING _____	08/29/2024

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01640	Continued From page 20 director and registered nurse (LALD/RN)-A and clinical nurse supervisor (CNS)-D stated the information on the provided resident roster was current. On August 27, 2024, at approximately 11:12 a.m., the surveyor observed unlicensed personnel (ULP)-B assist R2 with medication administration. ULP-B poured medications from a medication planner into a paper cup and gave to R2 with juice. ULP-B did not assist R2 with blood glucose monitoring nor take R2's blood pressure reading. R2's Nursing Uniform Assessment Tool dated August 9, 2024, indicated under "K. Treatments: List of treatments with description: none at this time." Also, under "L. Nursing Needs: Potential for nursing-delegated services: medication administration, de-escalation and redirection." The assessment lacked any indication R2 required assistance with blood glucose monitoring or blood pressure readings. On August 27, 2024, at 11:50 a.m., CNS-D explained they did not assist R2 with blood glucose monitoring and they did not have a blood glucometer (tests blood glucose levels) available for R2. CNS-D also stated they did not check R2's blood pressure daily, it was only checked during nursing assessments. CNS-D stated those two services should not have been on the service plan. The licensee's Service Plan policy dated August 1, 2021, read [licensee] will provide all services required by the current service plan. It also read the service plan must be revised, if needed, based on resident review or reassessment, and signed by a representative from [licensee] and the resident or resident's representative,	01640		

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	36925	A. BUILDING: _____ B. WING _____	08/29/2024

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01640	Continued From page 21 indicating agreement with the services to be provided. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01640		
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 medication administration was documented accurately 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01760		

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	36925	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01760	Continued From page 22 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 was admitted on March 22, 2023, and had diagnoses which included developmental disability, type 2 diabetes, personality disorder and post traumatic stress disorder (PTSD). R2's Service Plan signed March 22, 2023, indicated R2 received services including assistance with medication management. On August 27, 2024, at 11:15 a.m., during continuous observations, ULP-B was observed to assist multiple residents with medication administration, including R2. R2's prescriber orders signed on August 22, 2024, indicated R2 was prescribed arthritis pain relieving 0.075% cream twice daily, Refresh Tears 0.5% eye drops-one drop in each eye three times daily, fluticasone propionate 50 micrograms (mcg) nasal spray daily, and lidocaine 5% patch apply once daily. R2's medication administration record (MAR) dated August 1 through 27, 2024, lacked documentation of medication administration or refusal of medications for the following: -lidocaine 5% patch-apply at 8 a.m., for 1 dose; -lidocaine 5% patch-remove at 8 p.m., for 4 doses; -Refresh Tears 0.5% eye drops-administer three times per day, for 6 doses; -arthritis pain relief cream 0.075%-twice daily, for 3 doses; and -fluticasone nasal spray 50 mcg daily at 8 a.m.,	01760		

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	36925	A. BUILDING: _____ B. WING _____	08/29/2024

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01760	Continued From page 23 for 4 doses. On August 28, 2024, at 12:45 p.m., clinical nurse supervisor (CNS)-D stated she was sure R2 was receiving the eye drops because residents would tell staff when they did not get their medication. CNS-D stated staff were trained to initial and circle their initials if the resident refused the medication and would write on the back of the MAR the date, time, and medication refused. CNS-D stated staff were supposed to reapproach three times before the medication was considered refused. CNS-D further stated if there were no initials, then it would be considered missed charting. The licensee's Medication Documentation policy dated August 1, 2024, included "PROCEDURE: 1. Complete documentation of medication administration includes the following a. Resident's name b. Medication name c. Medication dosage d. Method/route of administration e. Signature and Title of staff administering the medication. 2. If the administration of one or more was not completed, staff will document the following a. The reason why the medication was not administered b. Follow up procedures to meet the resident's needs in compliance with the Medication Management Plan c. Appropriate notification to RN Supervisor or other persons as instructed regarding missed dosages d. Medication Error report, if appropriate 4. Documentation of medication administration and medication set up will be completed promptly."	01760		

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	36925	A. BUILDING: _____ B. WING _____	08/29/2024

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MILES VENTS INC	5336 SAILOR LANE BROOKLYN CENTER, MN 55429

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01760	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's	01790		

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01790	Continued From page 25 medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. 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) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36925	A. BUILDING: _____ B. WING _____	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILES VENTS INC	5336 SAILOR LANE BROOKLYN CENTER, MN 55429

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01790	Continued From page 26 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 the potential to affect a large portion or all of the residents). The findings include: The licensee lacked written procedures for packaging resident medications for unplanned time away. During the entrance conference on August 26, 2024, at 10:18 a.m., clinical nurse supervisor (CNS)-D stated the licensee provided medication management services for residents. During interview on August 27, 2024, at 10:19 a.m., ULP-B stated she was trained by the RN to package resident medications for unplanned times away. ULP-B stated the process was to put the medications in a small plastic bag and write the resident's name and time the medications are were to be given on the bag. ULP-B stated no other information was sent with the medications, and they documented on the medication administration record (MAR). ULP-B stated there were no written procedures to follow. During interview on August 27, 2024, at 10:58 a.m., CNS-D stated she trained ULPs to write the name, date and the time medications were to be given on the plastic bag then give them to the resident. CNS-D said they did not have written procedures and were not aware of the requirement. On August 27, 2024, at 11:15 a.m., during	01790		

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	36925	A. BUILDING: _____ B. WING _____	08/29/2024

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01790	Continued From page 27 ongoing observations, ULP-B was observed assisting multiple residents with medication administration. The licensee's Medication Management Plan for Residents Away from Home dated August 1, 2021, indicated the RN had developed written procedures/protocols for ULPs, including special instructions regarding controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01820 SS=D	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 were obtained for one of one resident (R2) receiving medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36925	A. BUILDING: _____ B. WING _____	08/29/2024

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01820	Continued From page 28 situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on March 22, 2023. R2's Service Plan signed March 22, 2023, indicated R2 received services to include assistance with medication management. R2's mental health provider orders dated July 30, 2024, included the following: -melatonin 10 milligrams (mg) nightly at bedtime; and -lorazepam 0.5 mg tablet-one tablet orally twice daily. R2's record included an "After Visit Summary" (AVS) dated August 22, 2024, from R2's primary provider which was not electronically signed. The AVS included the following: -melatonin 5 mg orally at bedtime for trouble sleeping; -albuterol 108 (90 base) micrograms (mcg)/act inhaler- inhale 1-2 puffs every 4 hours as needed (PRN) for asthma; and -ibuprofen 600 mg-1 tablet by mouth every 6 hours PRN for pain. On August 26, 2024, at 2:45 p.m., CNS-D stated they used R2's AVS to implement medication changes because the provider forgot to sign a medication list they had provided. CNS-D stated office assistant (OA) faxed the medication list to the provider to be signed. On August 27, 2024, at approximately 12:45 p.m., the licensee provided R2's now-signed medication list. The medication list included the following:	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01820	Continued From page 29 -melatonin 5 mg orally at bedtime; -alprazolam (Xanax) 0.5 mg-1 tablet orally twice a day for anxiety; -albuterol/Ventolin 90 mcg/ACT AERS inhalation nebulizer (incorrect route-an inhaler) solution every 4 hours PRN; and -ibuprofen 400 mg orally three times a day PRN. R2's Medication Administration Record (MAR) for August 2024, indicated R2 took the following medications: -lorazepam (Ativan) 0.5 mg-one tablet by mouth twice a day for anxiety (not included on the current order); -Ventolin HFA 90 mcg/act AERS-inhale 1-2 puffs by mouth every 4 hours PRN for asthma (current order indicated administer using nebulizer); -ibuprofen 600 mg orally every 6 hours PRN for pain (current order indicated 400 mg three times a day PRN); and -melatonin and alprazolam (Xanax) were not listed on the MAR, but were included on the current order. R2's medical record lacked documentation of the following: -lacked a discontinuation order for melatonin; -correct albuterol orders (inhaler vs nebulizer or both); -lacked signed prescriber order for ibuprofen 600 mg; and -clarification on lorazepam and alprazolam orders. On August 27, 2024, at 11:15 a.m., during continuous observations, ULP-B was observed to assist multiple residents, including R2, with medication administration. On August 28, 2024, at 3:01 p.m., licensed	01820		

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01820	Continued From page 30 assisted living director/registered nurse (LALD/RN)-A stated R2's mental health provider prescribed medications related to mental health and the primary provider handled the rest of her medications. LALD/RN-A stated R2 had been refusing the melatonin because it was not covered by insurance. CNS-D explained that alprazolam (Xanax) was not supposed to be on the medication list, but was supposed to be written as lorazepam and R2 no longer used the nebulizer, just the inhaler. LALD/RN-A stated for medications that were discontinued, they should have obtained orders to discontinue them. The licensee's Prescriber's Orders policy dated August 1, 2021, indicated written orders from an authorized prescriber would be obtained for all medications and treatments with which the assisted living facility assisted residents, including over the counter medications. Additionally, the policy indicated all orders must be signed and dated by the prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		

Minnesota Department of Health

3333 Division St #212
St. Cloud
320 223-7300

Type: Full
Date: *08/26/24*
Time: 11:00:00
Report: 1051241093

Food and Beverage Establishment Inspection Report

Location:
Miles Vents Inc
5336 Sailor Lane
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0038667
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632055880
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: YOGURT
Violation Issued: No

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

MET WITH NURSE EVALUATOR, ANNA BOHNEN
DISCUSSED THE FOLLOWING WITH OSE AGENE:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURE
REPORTABLE ILLNESSES AND SYMPTOMS

THE KITCHEN HAS A NSF 184 DISHWASHER, LAMINATE COUNTERTOPS WITH HOLLOW BASES, MDF WOODEN CABINETS, ORANGE PEEL TEXTURE CEILING, AND VINYL WOODEN FLOORS.

Type: Full
Date: *08/26/24*
Time: 11:00:00
Report: 1051241093
Miles Vents Inc

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 1051241093 of 08/26/24.

Certified Food Protection Manager: Aimugina B. Agene

Certification Number: FM108143 Expires: 09/01/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
Ose Agene

Signed: _____
Kai Yang
Public Health Sanitarian 1
St. Cloud
320 640-3532
Kai.Yang@state.mn.us