Electronically Delivered

October 25, 2024

Licensee
Tailored Care Residence Inc.
2311 10th Avenue South
Minneapolis, MN 55404

RE: Project Number(s) SL35613015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 4, 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 . . ."

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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35613	A. BUILDING: _____ B. WING _____	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAILORED CARE RESIDENCE INC	2311 10TH 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 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: SL35613015-0 On September 30, 2024, through October 4, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 4 residents receiving services under the 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.	
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management	0 580		

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0 580	Continued From page 1 appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of ongoing quality management activities relevant to the size and services provided by the assisted living provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During an interview on October 1, 2024, at 11:55 a.m., registered nurse (RN)-A stated the licensee conducted staff meetings frequently to discuss resident care and concerns; however, the licensee had not developed or documented any quality management activities.	0 580		

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0 580	Continued From page 2 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included a facility TB risk 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	0 660		

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0 660	Continued From page 3 cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 30, 2024, at approximately 10:40 a.m. with registered nurse (RN-A), a request was made to review the facility TB risk assessment. RN-A stated the licensee had completed a facility TB risk assessment but was unsure where to locate it. RN-A stated the licensee would attempt to find the assessment and provide to surveyor. At the time of exit on October 4, 2024, at 3:00 p.m., the licensee had not provided a TB risk assessment to surveyor. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. 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	0 680		

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0 680	Continued From page 4 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing 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. This had the potential to affect all residents under the assisted living license. 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).	0 680		

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0 680	Continued From page 5 The findings include: The licensee's undated EPP lacked evidence of the following required content: - annual review of the EPP; - quarterly review of missing resident policy; - EPP related to patient population; - process for emergency preparedness (EP) collaboration; - subsistence needs for staff and residents; - policies and procedures for sheltering in place; - policies and procedures for medical documents; - policies and procedures for volunteers; - roles under wavier declared by secretary; - emergency officials contact information; - methods for sharing information; - long term care family notifications; and - emergency prep testing to include a disaster drill. On October 1, 2024, at 12:10 p.m., registered nurse (RN)-A stated the documents provided to surveyor were the complete emergency disaster preparedness plan. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have a plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The plan would be reviewed and updated at least annually. In addition, a disaster drill would be documented and conducted at the residence at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 780		

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0 780	Continued From page 7 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). Findings include: On a facility tour on October 1, 2024, from 11:15 a.m. to 12:00 p.m., with licensed assisted living director (LALD)-C, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code: CIGARETTE BUTT DISPOSAL There was a plastic container provided for disposal of cigarette butts on the front porch in the designated smoking area. Containers used for disposal of used cigarette butts and smoking material are required to be non-combustible or manufactured for the purpose of dispensing used cigarette and smoking materials. There were used cigarette butts on the floor of resident sleeping room three. Used cigarette butts are required to be dispensed in suitable non-combustible containers in accordance with the facility smoking policy. SMOKE ALARMS There was existing electrical wiring installed for hardwired (receiving power from the building electrical system) smoke alarms were required throughout the facility. It was observed that all hardwired smoke alarms were removed and replaced with battery operated smoke alarms throughout facility. Existing hardwired smoke alarms are required to	0 780		

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0 780	Continued From page 8 be maintained hardwired as installed at the time of construction. During an interview on October 1, 2024, at 11:30 a.m., LALD-C, stated the existing hardwired smoke alarms were removed and replaced with all battery-operated smoke alarms. The smoke alarm in resident sleeping room one was covered with a cloth. Smoke alarms are required to be maintained free of obstructions that effect the detection of smoke in the event of a fire or similar emergency. EMERGENCY ESCAPE AND RESCUE WINDOWS The window well cover was obstructing the emergency escape and rescue window from opening in unoccupied resident sleeping room one. Emergency escape and rescue windows are required to be maintained without obstructions that prevent the full and immediate use of the window in the event of a fire or similar emergency. The window well height from the bottom surface to the top of the window well measured 46 inches high in resident sleeping room one. Emergency escape and rescue window wells exceeding 44 inches in height are required to be provided with a ladder in accordance with Minnesota State Fire Code requirements. DOOR LOCKING There was padlock hasp hardware that did not allow exiting from the inside installed on the	0 780		

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0 780	Continued From page 9 outside of the exit access door (door leading out of a room or space to the exit) leading out of the laundry room. Exit access doors are required to be readily openable from the inside of all rooms and spaces for the purpose of exiting in the event of a fire or similar emergency. LOCKED EXTERIOR EXIT GATES The exit door from the back of the kitchen area was provided with an exit sign leading to the back yard for exiting. The gates leading to the public way (sidewalk, driveway, street) had chain and padlocks installed in the exterior exit path in the back yard preventing access to the public way. All marked exit doors are required have exit paths maintained from the exit door through the exterior exit path to the public way without locks or latches that require keys, tools, or special knowledge. During the tour while the surveyor was onsite, LALD-C, removed the exit sign from the back door leading out of the kitchen area. GENERAL FIRE CODE REQUIREMENTS The electrical light fixtures were missing bulbs exposing powered electrical connections in the upstairs and basement bathrooms. Electrical light bulbs are required to be maintained in place to prevent accidental contact with unprotected powered electrical connections. The resident room doors were not provided with numbers matching the numbers on the posted FSEP evacuation floor plan. Resident room doors are required to be provided with numbers matching the posted evacuation floor plan in order to lead occupants of the building to an exit in the event of a fire or similar emergency.	0 780		

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0 780	Continued From page 10 There was a missing electrical fixture light globe cover in the closet of resident sleeping room two. Electrical light fixtures are required to be maintained with all covers in accordance with manufactures installation instructions. An electrical outlet was missing the cover in resident sleeping room two. Electrical outlet covers are required to be maintained in place to prevent accidental contact with powered electrical connections in the electrical box. During the facility tour LALD-C, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=D	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 facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential	0 800		

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0 800	Continued From page 11 to affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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). Findings include: On a facility tour on October 1, 2024, from 11:15 a.m. to 12:00 p.m., with licensed assisted living director (LALD)-C, the surveyor made the following observations of facility disrepair: There was a ceiling panel missing and on the floor in the basement bathroom. During the facility tour LALD-C, verified the above listed observations while accompanying on the tour. 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 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;	0 810		

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0 810	Continued From page 12 (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 required content, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35613	A. BUILDING: _____ B. WING _____	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAILORED CARE RESIDENCE INC	2311 10TH AVENUE SOUTH MINNEAPOLIS, MN 55404

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0 810	Continued From page 13 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 October 1, 2024, from 10:45 a.m., licensed assisted living director (LALD)-C, 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 provided FSEP, failed to include the following: The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. The available 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 FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. During an interview on October 1, 2024, at 10:55 a.m., LALD-C, stated documentation was not available in the FSEP for resident actions to be taken and resident evacuation status/ unique needs for evacuation in writing and available in	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 810	Continued From page 14 the plan. TRAINING Record review of the available documentation indicated the licensee failed to provided evacuation training to residents at least once per year as evident by not providing documentation FSEP training was provided to residents as required. During an interview on October 1, 2024, at 11:05 a.m., LALD-C, stated training was provided to residents during the drills but documentation was not available indicating FSEP resident training was provided as required. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by providing documentation evacuation drills were completed August 22, 2024, and August 31, 2024, only. No further documentation was provided. During an interview on October 1, 2024, at 11:15 a.m., LALD-C, stated documentation was not available indicating evacuation drills were completed every other month and twice per shift per year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

Minnesota Department of Health

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

Type: Full
Date: *10/02/24*
Time: 16:00:00
Report: 8087241204

Food and Beverage Establishment Inspection Report

Location:

Tailored Care Residence Inc
Tailrored Care Residence Inc
2311 10th Avenue South
Minneapolis, MN55404
Hennepin County, 27

Establishment Info:

ID #: 0039136
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122846370
ID #:

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Ambient Air
Temperature: 9 Degrees Fahrenheit - Location: WHIRLPOOL FREEZER
Violation Issued: No

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

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

Process/Item: Cold Holding: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: WHIRLPOOL REFRIGERATOR
Violation Issued: No

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

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF NURSE EVALUATOR II ELYSE JONES.

FLOORS ARE LAMINATE, CABINETS ARE HARDWOOD AND CEILING DOES NOT APPEAR TO BE DURABLE, SMOOTH IN TEXTURE AND EASILY CLEANABLE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

Type: Full
Date: *10/02/24*
Time: 16:00:00
Report: 8087241204
Tailored Care Residence Inc

Food and Beverage Establishment Inspection Report

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

DESIGNATED HAND WASHING SINK IN THE KITCHEN (RIGHT SIDE OF 2-BIN, STAINLESS STEEL, RESIDENTIAL SINK).

INSPECTION REPORT EMAILED TO NURSE EVALUATOR II ELYSE JONES.

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 8087241204 of 10/02/24.

Certified Food Protection Manager: AYAN MAOW

Certification Number: FM109450 Expires: 11/16/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

ASMA MOHAMED
CARE TAKER

Signed: _____

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