Electronically Delivered

August 3, 2022

Administrator
Lindstrom Senior Living
30455 Lehigh Avenue
Lindstrom, MN 55045

RE: Project Number(s) SL37816015

Dear Administrator:

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

The Minnesota Department of Health completed a an initial evaluation on July 7, 2022, for the purpose of assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

**IMPOSITION OF FINES**
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

**DOCUMENTATION OF ACTION TO COMPLY**

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

**CORRECTION ORDER RECONSIDERATION PROCESS**

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

A state licensing order under Minn. Stat. § 144G.91 Subd. 8), Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general Free from Maltreatment reconsideration

reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Carrie Euerle, Interim Supervisor
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: 651-242-8846 Fax: 651-281-9796

PMB

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 37816 | A. BUILDING: _____ B. WING _____ | 07/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LINDSTROM SENIOR LIVING | 30455 LEHIGH AVENUE LINDSTROM, MN 55045 |

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| 0 000 | Initial Comments<br><br>Initial comments<br>******ATTENTION******<br><br>ASSISTED LIVING LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey/a complaint investigation.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL37816015<br><br>On July 5, 2022 through July 7, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey/investigation, there were 18 residents receiving services under the provider ' s Provisional Assisted Living/with Dementia Care license | 0 000 | SL#37816015<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care/Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors ' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements<br><br>(13) offer to provide or make available at least the | 0 480 | | |

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| 0 480 | Continued From page 1<br>following services to residents:<br><br>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:<br><br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 26, 2022, for the specific Minnesota Food Code deficiencies.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 480 | | |

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| 0 495 SS=F | 144G.41 Subd. 1 (14) Minimum Requirements<br><br>(14) provide staff access to an on-call registered nurse 24 hours per day, seven days per week.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and document review, the licensee failed to ensure a registered nurse was available 24 hours a day, seven days a week to provide consultation to staff performing delegated nursing tasks and services. This had the potential to affect all eighteen (18) residents receiving assisted living services.<br><br>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).<br><br>The findings include:<br><br>The licensee's July 1-31, 2022, on call schedule posted on the wall of the 2nd floor charting area indicated licensed practical nurse (LPN)-B was on call during July 2, 3, 4, 16, 17 and 30, 2022. On the six days indicating LPN-B was on call there was also not telephone contact information posted for a registered nurse (RN).<br><br>On July 7, 2022, RN-A during an interview at approximately 2:00 p.m. verified LPN-B was indicated to be on call every other weekend, but the LPN-B could contact the RN if needed. | 0 495 | | |

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| 0 495 | Continued From page 3<br><br>The licensee's policy, 6.12 Availability of an RN for Staff policy dated August 1, 2021, indicated in accordance with 144G.62 Subd. 1 will have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. The RN must be readily available either in person, by telephone, or by other means to the staff at times when the staff is providing services.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 495 | | |
| 0 510 SS=D | 144G.41 Subd. 3 Infection control program<br><br>(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.<br>(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.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure staff completed proper infection control technique for one of one unlicensed personnel (ULP)-C observed during R7's blood glucose check and medication administration. | 0 510 | | |

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| 0 510 | Continued From page 4<br><br>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)<br><br>Findings include:<br><br>R7's diagnoses included diabetes mellitus. R7's medication administration record indicated R7 received blood glucose checks with his morning and bedtime medication passes.<br><br>During an observation on July 6, 2022 at 7:39 a.m., ULP-C failed to remove her gloves and wash her hands in between a blood glucose check and medication administration. ULP-C washed her hands and applied gloves. ULP-C then completed a blood glucose check on R7. ULP-C kept her gloves on while she disposed of the lancet into the sharps container. ULP-C failed to clean and disinfect the glucometer after use. ULP-C proceeded to complete R7's medication administration, wearing the same gloves. ULP-C removed and disposed of her gloves after completing medication administration then exited the resident's apartment and washed her hands in a restroom down the hall.<br><br>During an interview on July 7, 2022 at 11:45 a.m., registered nurse (RN)-A stated staff should be washing their hands after a blood glucose check and before medication administration.<br><br>A policy titled Blood Sugar Testing-Single Equipment Use, effective date July 26, 2021, | 0 510 | | |

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| 0 510 | Continued From page 5<br>indicated the procedure for blood sugar testing included cleaning and disinfecting the glucometer, then removing and disposing gloves, and washing hands.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) Days | 0 510 | | |
| 0 580 SS=C | 144G.42 Subd. 2 Quality management<br><br>The facility shall engage in quality management 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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to engage in quality management activity appropriate to the size of the facility, relevant to the type of services provided, and failed to maintain documentation on quality management activities. This had the potential to affect all eighteen (18) residents receiving assisted living services.<br><br>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 | 0 580 | | |

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| 0 580 | Continued From page 6<br>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).<br><br>Findings include:<br><br>During the provisional assisted living facility (PALF) entrance conference on July 7, 2022, at approximately 2:00 p.m., a copy of the facility's quality management plan was requested from the registered nurse (RN)-A.<br><br>The licensee's policy, 2.31 Quality Management Project policy dated August 1, 2021, indicated in accordance with 144G.62 Subd. 1 will have engage in quality management 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."<br><br>RN-A stated she had been working on a plan although did not have a completed documented quality management plan.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 580 | | |

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| 0 620 SS=E | 144G.42 Subd. 6 (a) Compliance with requirements for reporting ma<br><br>144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan.<br>(a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the facility failed to report a physical injury of unknown origin to the Minnesota Adult Abuse Reporting Center (MARRC) within 24 hours of staff becoming aware of the incident for two of two residents (R1, R4).<br><br>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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>Findings include:<br><br>During the provisional assisted living facility (PALF) entrance conference on July 6, 2022, at approximately 2:00 p.m., R1 and R4 records were requested from the registered nurse (RN)-A.<br><br>R1's diagnoses included Atherosclerotic heart | 0 620 | | |

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| 0 620 | Continued From page 8<br>disease of native coronary artery without angina.<br><br>R1's uniform assessment dated February 1, 2022, indicated R1 received services to include assistance with activities of daily living (ADLs), housekeeping, and laundry.<br><br>Review of a facility incident report dated June 26, 2022, at 7:45 a.m. indicated R1 found on floor of living room by son who alerted staff. Resident was reported to have sustained skin tear, bruise, swelling, pain and hit head. Resident was transport to hospital by ambulance and diagnosed with a fracture to right wrist. RN was notified June 26, 2022, 8:00 a.m.<br><br>R4's diagnoses included. Cerebral infarction, Secondary hypertension, Anxiety disorder, Benign prostatic hyperplasia, Pulmonary fibrosis, Paroxysmal atrial fibrillation.<br><br>R4's service plan dated January 19, 2022, indicated R4 received services to include medication administration, assistance with activities of daily living (ADLs), housekeeping, and laundry.<br><br>Review of a facility incident report resident form dated February 1, 2022, no time was recorded, indicated R4 had an alleged fall. R4 wife informed staff February 2, 2022 that resident had fall overnight. RN was notified of incident February 2, 2022 10:00 a.m. Licensed practical nurse (LPN)-B entered an additional note dated February 3, 2022 that indicated that staff had reported a bruise on R4's left forearm which was assessed by LPN-B.<br><br>The facility's Incident Reporting (Involving Clients, Independent Residents visitors, and Staff) policy | 0 620 | | |

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| 0 620 | Continued From page 9<br>dated December 2, 2020, indicated reportable incidents would be submitted to the Common Entry Point as soon as possible and no later than 24 hours after the incident.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 620 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing tenant residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule. | 0 680 | | |

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| 0 680 | Continued From page 10<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and record review, the licensee failed to ensure the facility emergency preparedness (EP) plan contained all the required components. This had the potential to affect all eighteen (18) residents receiving assisted living services, staff, and visitors.<br><br>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).<br><br>Findings include:<br><br>On July 5, 2022, at approximately 11:00 a.m., during the entrance conference with the registered nurse (RN)-A, a request was made to view the licensee's emergency preparedness plan.<br><br>The plan was centrally located in the facility's office area and contained a binder, titled "Emergency Plan".<br><br>The licensee's plan lacked the following required content:<br>Maintain and Annual EP Updates<br>EP Program Patient Population<br>Process for EP Collaboration<br>Subsistence Needs for Staff and Patients<br>Procedures for Tracking of Staff and Patients<br>Policies and Procedures for Volunteers<br>Sharing Information on Occupancy/Needs | 0 680 | | |

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| 0 680 | Continued From page 11<br><br>Emergency Prep Training and Testing<br>Emergency Prep Training Program<br>Emergency Prep Testing Requirements<br><br>On July 7, 2022, the surveyor reviewed the emergency preparedness plan and components with the administrator (AD)-F and RN-A.<br><br>The licensee's undated policy titled Lindstrom Senior Living Preparedness Plan indicated the facility would be prepared to manage emergency and disaster situations, including missing residents through a hazard assessment and emergency planning.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 0 680 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of all residents and staff. | 0 800 | | |

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| 0 800 | Continued From page 12<br><br>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).<br><br>The findings include:<br><br>On July 6, 2022, between the hours of 11:00 a.m. and 12:40 p.m. and again between the hours of 1:30 p.m. to 3:20 p.m., survey staff toured the facility with the unlicensed personnel (ULP)-J. During the tour survey staff observed and the ULP-J verified the following findings:<br><br>1) The fire-rated doors to the garage trash room and elevator equipment room failed to self-close and latch to maintain the fire rating of the rooms.<br>2) The corridor doors to the first level laundry room, housekeeping, and trash room hardware were compromised with hardware parts tampered with and/or removed, and therefore, the doors failed to self-close and latch to protect the corridor pathway. The ULP-J stated that he did not know the reason for the occurrences.<br>3) An exit door (south stair floor B) leading to the outside failed to latch.<br>4) The fire suppression sprinkler in room 127 was covered with a piece of plastic.<br>5) The unoccupied resident rooms, 108, 125, 127, and 140 were observed with dried-out plumbing toilet traps which would allow sewer gas to enter the building environment creating unsafe and health risks to residents and employees. The ULP-J verified the findings.<br>6) The toilet in unoccupied resident room 137 had | 0 800 | | |

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| 0 800 | Continued From page 13<br>mold growth (dark color throughout the wall submerged in water inside the bowl).<br>The ULP-J stated that the mold was probably from the toilet being exposed to direct daylight.<br><br>On July 6, 2022, at approximately 3:30 p.m., the ULP-J acknowledged the findings during the exit interview.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the | 0 810 | | |

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| 0 810 | Continued From page 14<br>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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, record review, and interview, the licensee failed to provide all required content on the fire safety and evacuation plan, and the minimum number of evacuation drills. This has the potential to directly affect the safety all residents receiving care, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On July 6, 2022, between the hours of 11:00 a.m. and 12:40 p.m. and again between the hours of 1:30 p.m. to 3:20 p.m., survey staff toured the facility with the unlicensed personnel (ULP)-J.<br><br>On July 6, 2022, at approximately 12:40 p.m., survey staff reviewed the facility's fire safety and evacuation plan, drill, and training documentation. | 0 810 | | |

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| 0 810 | Continued From page 15<br>The documentation review indicated the following findings:<br><br>FIRE SAFETY and EVACUATION PLAN<br>-The building floor plan layout included exit routes but lacked with location and number of resident sleeping rooms.<br>-The fire safety and evacuation plan lacked fire protection procedures for residents.<br><br>FIRE AND EVACUATION DRILLS<br>Record review indicated the employee fire drills did not meet the minimum required two fire and evacuation drills per shift per year, at minimum one every other month (with a minimum total of six drills in a year) as prescribed in their fire policy document dated July 26, 2021, and in accordance with Minnesota Statutes. The record of fire drills performed by the employees was documented on January 18, 2022, covering two shifts, 3:00 p.m. and 3:00 a.m., and February (no year documented) covering two shifts, 3:00 p.m. and 3:00 a.m. No drills records were performed or available for review between March 2022 through June 2022.<br><br>On July 6, 2022, at approximately 3:30 p.m., the ULP-J acknowledged the findings during the exit interview.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Fourteen (14) days | 0 810 | | |
| 0 900 SS=D | 144G.50 Subdivision 1 Contract required<br><br>(a) An assisted living facility may not offer or provide housing or assisted living services to any | 0 900 | | |

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| 0 900 | Continued From page 16<br>individual unless it has executed a written contract with the resident.<br><br>(b) The contract must contain all the terms concerning the provision of:<br>(1) housing;<br>(2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and<br>(3) the resident's service plan, if applicable.<br><br>(c) A facility must:<br>(1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and<br>(2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed.<br><br>(d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37.<br><br>(e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3.<br><br>(f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure a resident or representative signed a written contract prior to | 0 900 | | |

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| 0 900 | Continued From page 17<br>initiation of services for one of four (R8) resident contracts reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>Findings include:<br><br>R8 admitted to the licensee's memory care unit on March 14, 2022. R8's diagnoses included Alzheimer's disease. R8's signed service agreement dated March 14, 2022, indicated R8 received services including medication set up. R8's initial nursing assessment dated March 14, 2022 indicated R8 required full assistance with medication administration. R8's March 2022 medication administration record (MAR) indicated R8 received medication administration and COVID-19 monitoring beginning March 14, 2022.<br><br>R8's responsible party signed the resident agreement on March 22, 2022.<br><br>During an interview on July 7, 2022 at 11:45 a.m., registered nurse (RN)-A confirmed R8's services started on the date of her admission, March 14, 2022.<br><br>The licensee failed to provide a policy referencing the requirement for a signed contract to be in place prior to providing assisted living services as indicated in Minnesota Statute 144G.50 Subd. 1.<br><br>TIME PERIOD FOR CORRECTION: Twenty One | 0 900 | | |

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| 0 900 | Continued From page 18<br>(21) Days | 0 900 | | |
| 0 970 SS=F | 144.50 Subd. 5 Waivers of liability prohibited<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>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.<br><br>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).<br><br>The findings include:<br><br>R7's Resident Agreement dated February 2, 2022, included a clause identified as 29. INDEMNIFICATION that indicated the resident would waive the facility's liability as follows: | 0 970 | | |

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| 0 970 | Continued From page 19<br><br>As an occupant of the Community, Resident assumes the risk for Resident's own safety and for the safety of Resident's guests and agents. Resident will Indemnify and hold harmless Lindstrom Senior Living, its employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense In connection with loss of life, personal Injury or damage to or loss of property, arising from or out of, or caused wholly or In part by, an act or omission of Resident or Resident's guests or agents.<br><br>On July 7, 2022, at approximately 10:00 a.m., registered nurse (RN)-A confirmed R7's Resident Agreement was the same assisted living service agreement was used for all residents at the facility.<br><br>The licensee lacked a policy for Assisted Living Licensure contract requirements, effective August 1, 2021.<br><br>No further information available.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 970 | | |
| 01420 SS=D | 144G.62 Subd. 2 Delegation of assisted living services<br><br>(b) When the registered nurse or licensed health professional delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks. If an | 01420 | | |

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| 01420 | Continued From page 20<br>unlicensed personnel has not regularly performed the delegated assisted living task for a period of 24 consecutive months, the unlicensed personnel must demonstrate competency in the task to the registered nurse or appropriate licensed health professional. The registered nurse or licensed health professional must document instructions for the delegated tasks in the resident's record.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure two of two unlicensed personnel (ULP) (ULP-G, ULP-H) were trained and deemed competent on the proper use R7's mechanical sit-to-stand lift and ankle-foot orthosis (AFO) brace prior completing these delegated tasks.<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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).<br><br>Findings include:<br><br>R7's diagnoses included cerebrovascular disease and hemiplegia. R7's signed service agreement dated May 20, 2022, indicated the resident received services including assistance with transferring.<br><br>R7's service plan dated July 6, 2022, indicated the resident transferred with assistance of his sit-to-stand lift for transfers when tired. This service plan also included a repositioning | 01420 | | |

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| 01420 | Continued From page 21<br>schedule effective June 8, 2022, indicating the staff were to apply the AFO brace on his left lower extremity daily from 9:30 a.m. to 12:30 p.m.<br><br>R7's medical record lacked evidence of sit-to-stand and AFO brace training and skill competencies completed by ULPs.<br><br>ULP-G's personnel record lacked evidence of training and skill competencies on R7's mechanical sit-to-stand lift and AFO brace.<br><br>ULP-H's personnel record lacked evidence of training and skill competencies on R7's mechanical sit-to-stand lift and AFO brace.<br><br>During an interview on July 7, 2022 at 11:45 a.m., registered nurse (RN)-A stated R7's home care agency completed training with ULPs on his sit-to-stand lift and AFO brace and stated the licensee did not have documentation of training. RN-A stated she went through R7's sit-to-stand information sheet with ULP-G and ULP-H but did not complete hands on training or ensure they signed off on the training. RN-A stated the licensee had no way of showing any given ULP completed training and passed a skill competency prior to applying the AFO brace.<br><br>A policy titled Competency Training Evaluations, effective July 15, 2021, indicated the licensee would ensure ULPs were trained and competent in the proper methods to perform the tasks or procedures for each client, including AFO braces and the use of mechanical lifts.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) Days | 01420 | | |

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| 01440 | Continued From page 22 | 01440 | | |
| 01440 SS=F | 144G.62 Subd. 4 Supervision of staff providing delegated nurs<br><br>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to complete 30-day competency evaluations for two of two unlicensed personnel (ULP) (ULP-G, ULP-H) with records reviewed.<br><br>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected | 01440 | | |

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| LINDSTROM SENIOR LIVING | 30455 LEHIGH AVENUE LINDSTROM, MN 55045 |

| (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 |
|---|---|---|---|---|
| 01440 | Continued From page 23<br>or has the potential to affect a large portion or all of the clients).<br><br>Findings include:<br><br>Upon request of ULP-G's and ULP-H's 30-day competency reviews, the licensee provided ULP-G's and ULP-H's performance reviews.<br><br>ULP-G's 30-day review, signed and dated April 19, 2022, indicated registered nurse (RN)-A completed a performance review. This performance review failed to address the requirement of direct supervision of ULP-G performing delegated tasks.<br><br>ULP H's 30-day review, signed and dated March 22, 2022, indicated RN-A completed a performance review. This performance review failed to address the requirement of direct supervision of ULP-H performing delegated tasks.<br><br>During an interview on July 7, 2022 at 12:29 p.m., RN-A stated the performance reviews were the 30-day reviews after ULP-G and ULP-H began providing services.<br><br>A policy titled, Supervision of Staff-Delegated Services, effective July 25, 2021, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the day the staff member first performs the delegated tasks for residents.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) Days | 01440 | | |

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|---|---|---|---|
| | 37816 | A. BUILDING: _____ B. WING _____ | 07/07/2022 |

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|---|---|---|---|---|
| 01700 | Continued From page 24 | 01700 | | |
| 01700 SS=D | 144G.71 Subd. 2 Provision of medication management services<br><br>(a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues.<br>(b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview, observation, and record review, the licensee failed to ensure the registered nurse (RN)-A, conducted an individualized assessment to determine what Assisted Living services would be provided, and how the services would be provided for one of | 01700 | | |

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| 01700 | Continued From page 25<br>four residents (R4) with records reviewed.<br><br>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 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).<br><br>The findings include:<br><br>During the entrance conference on July 5, 2022, at approximately 11:00 a.m., registered nurse RN-A confirmed the licensee provided medication management services to all assisted Living and Memory Care residents at the facility.<br><br>During the provisional assisted living facility (PALF) entrance conference on July 6, 2022, at approximately 2:00 p.m., R4 records were requested from the registered nurse RN-A.<br><br>R4's diagnoses included. Cerebral infarction, Secondary hypertension, Anxiety disorder, Benign prostatic hyperplasia, Pulmonary fibrosis, Paroxysmal atrial fibrillation.<br><br>R4's service plan dated January 19, 2022, indicated R4 received services to include medication administration, assistance with activities of daily living (ADLs), housekeeping, and laundry.<br><br>R4's records lacked evidence a registered nurse conducted a face-to-face assessment to determine what medication management services | 01700 | | |

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| 01700 | Continued From page 26<br>would be provided and how they would be provided. In addition, R4's records indicate that licensed practical nurse (LPN)-B electronically signed the Uniform Assessment Tool dated January 18, 2022.<br><br>The licensee's policy titled 6.01 Assessments, Reviews & Monitoring indicated a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person, be in writing, dated, and signed by the registered nurse who conducted the assessment.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 01700 | | |
| 02040 SS=F | 144G.81 Subdivision 1 Fire protection and physical environment<br><br>An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements:<br>(1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and<br>(2) the facility shall be protected throughout by an | 02040 | | |

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| 02040 | Continued From page 27<br>approved supervised automatic sprinkler system by August 1, 2029.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, document review, and interview, the licensee failed to provide a complete hazard vulnerability or safety risk assessment plan to identify hazard vulnerabilities and mitigations on and around the property to protect the residents from potential harm. This has the potential to directly affect all memory care residents receiving assisted living services.<br><br>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 residents).<br><br>The findings include:<br><br>On July 6, 2022, between the hours of 11:00 a.m. and 12:40 p.m. and again between the hours of 1:30 p.m. to 3:20 p.m., survey staff toured the facility with the unlicensed personnel (ULP)-J.<br><br>On July 6, 2022, at approximately 12:40 p.m., survey staff reviewed the facility 's hazard vulnerability assessment plan, Hazard VA Tool, dated December 21, 2021.<br><br>-The plan documentation was incomplete and lacked local site-specific hazard content on the assessment on and around the property to protect the memory care residents from harm. Hazard assessments on the plan must also | 02040 | | |

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|---|---|---|---|---|
| 02040 | Continued From page 28 | 02040 | | |

include risks or potential hazard vulnerabilities such as resident elopement as a potential risk from the deactivation of power doors due to loss of power or fire alarm activation, the risk of the resident room windows being compromised over time such as resident room #136, the risks of elopement for openings between the building wall and the fence in the courtyard at 4-6 inches wide gaps on both sides of the fence, the risks of harm for residents with sharp tools such as resident room #131 with large knives in a drawer and a toaster, the risks of misuse of cleaning chemicals not secured, the risks of the misuse by accessing the unsecured portable fire extinguishers and/or architectural accessories, and potential risk around the property such as busy roads and heavily wooded areas due to resident elopement.

- The plan documentation lacked mitigation to each assessed risk to ensure effectively respond to all potential hazards that could directly affect all memory care residents. Specific prevention measures to mitigate risks from the identified potential hazard and vulnerability assessment must be developed and documented in the plan for all potential harm.

On July 6, 2022, at approximately 3:30 p.m., survey staff discussed the findings and explained to ULP-J that all potential safety risks or harm on and around the property must be identified, assessed, mitigated, and documented in the facility ' s HVA plan. The ULP-J acknowledged the findings at the exit interview.

No further information was provided.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

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| 02170 | Continued From page 29 | 02170 | | |
| 02170 SS=F | 144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA<br><br>(b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following:<br>(1) past and current interests;<br>(2) current abilities and skills;<br>(3) emotional and social needs and patterns;<br>(4) physical abilities and limitations;<br>(5) adaptations necessary for the resident to participate; and<br>(6) identification of activities for behavioral interventions.<br>(c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs.<br>(d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to:<br>(1) occupation or chore related tasks;<br>(2) scheduled and planned events such as entertainment or outings;<br>(3) spontaneous activities for enjoyment or those that may help defuse a behavior;<br>(4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music;<br>(5) spiritual, creative, and intellectual activities;<br>(6) sensory stimulation activities;<br>(7) physical activities that enhance or maintain a resident's ability to ambulate or move; and<br>(8) outdoor activities. | 02170 | | |

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| 02170 | Continued From page 30<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to evaluate and develop a written, individualized activity plan addressing the six components for one of one (R8) residents reviewed with Alzheimer's disease or other dementia. This affected all residents receiving care under the dementia care license.<br><br>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).<br><br>Findings include:<br><br>R8 resided in the licensee's memory care unit. R8's diagnoses included Alzheimer's disease. R8's signed service agreement dated March 21, 2022, indicated R8 received services including standby assistance and cueing with activities of daily living including oral care, grooming, and dressing.<br><br>R8's record lacked an evaluation and written individualized activity plan addressing all six provisions: past and current interests, current abilities and skills, emotional and social needs and patterns, physical abilities and limitations, adaptations necessary for the resident to participate, and identification of activities for behavioral interventions.<br><br>During an interview on July 7, 2022 at 11:39 a.m., unlicensed personnel (ULP)-M stated she did not | 02170 | | |

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| 02170 | Continued From page 31<br>create written, individualized activity plans for the residents. ULP-M stated she had not seen the new rules referring to this requirement.<br><br>A policy titled ALDC Life Enrichment Programs, Activities and Outdoor Space, effective date July 15, 2021, indicated each resident would be evaluated for past and current interests, current abilities and skills, emotional and social needs and patterns, physical abilities and limitations, adaptations necessary for the resident to participate, and identification of activities for behavioral interventions. This policy also indicated an individualized activity plan would be developed for each resident based on their activity evaluation.<br><br>TIME PERIOD FOR CORRECTION: Twenty One (21) Days | 02170 | | |

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
St. Paul
651-201-4500

Type: Full
Date: *07/08/22*
Time: 12:18:53
Report: 8059221017

# Food and Beverage Establishment Inspection Report



**Location:**
Lindstrom Senior Living
30455 Lehigh Avenue
Lindstrom, MN55045
Chisago County, 13

**Establishment Info:**
ID #: 0040437
Risk:
Announced Inspection: No

**License Categories:**

Expires on: 12/31/22

**Operator:**

Phone #:
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.

**2-200 Employee Health**

2-201.12D(2) ** Priority 1 **

MN Rule 4626.0045D Food employees with an open lesion on their hands, wrists, or arms must cover the wound with an impermeable covering such as a finger cot or bandage. A single-use glove must also be worn over a bandaged hand.

EMPLOYEE SEEN WITH OPEN LESION ON THEIR ARM. EMPLOYEE BANDAGED LESION.

*Corrected on Site*

**4-500 Equipment Maintenance and Operation**

4-502.11B ** Priority 2 **

MN Rule 4626.0820B Calibrate food temperature measuring devices in accordance with manufacturer's specifications as often as necessary to ensure accuracy.

TWO THERMOMETERS WERE FOUND OUT OF CALIBRATION. CALIBRATE THERMOMETERS.

*Comply By: 07/08/22*

**4-200 Equipment Design and Construction**

4-201.11AMN

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

HOUSEHOLD CROCK POT IS NOT ANSI CERTIFED. REMOVE OR REPLACE EQUIPMENT.

*Comply By: 07/08/22*

**4-400 Equipment Location and Installation**

4-402.11A

MN Rule 4626.0725A Space fixed equipment to allow access for cleaning along the sides, behind and above the unit, or seal to adjoining equipment or walls.

HANDWASHING SINK NEXT TO ICE MACHINE IS NOT SEALED TO ADJOINING WALL BEHIND IT. CAULK SINK TO WALL.

*Comply By: 08/05/22*

**Surface and Equipment Sanitizers**

Hot Water: = at 168 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Ecolab Sink and Surface: = 272 at Degrees Fahrenheit
Location: Three compartment sink
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cold Hold/Egg
Temperature: 36 Degrees Fahrenheit - Location: Walk-in
Violation Issued: No

Process/Item: Cooling/Pasta Salad
Temperature: 61 Degrees Fahrenheit - Location: Cooling for 2 hrs in the walk-in
Violation Issued: No

Process/Item: Cook Temp/Shrimp from raw
Temperature: 166 Degrees Fahrenheit - Location: Deep fryer
Violation Issued: No

Process/Item: Hot Hold/Broccoli
Temperature: 150 Degrees Fahrenheit - Location: Steam well
Violation Issued: No

Process/Item: Hot Hold/Rice
Temperature: 156 Degrees Fahrenheit - Location: Steam well
Violation Issued: No

Process/Item: Hot Hold/Soup
Temperature: 177 Degrees Fahrenheit - Location: Soup warmer
Violation Issued: No

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

# 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 8059221017 of 07/08/22.

Certified Food Protection Manager: Jena Biermaier

Certification Number: 103427 Expires: 03/03/23

Signed: _____

Jena Biermaier
Executive CHef

Signed: _____

James Noyola
Sanitarian Supervisor
St. Paul
651-201-4929
health.foodlodging@state.mn.us