Electronically Delivered

May 5, 2026

Licensee
Sunset Homes Assisted Living
9938 18th Avenue Northwest
Oronoco, MN 55960

RE: Project Number(s) SL36995016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 29, 2026, 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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36995	A. BUILDING: _____ B. WING _____	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNSET HOMES ASSISTED LIVING	9938 18TH AVENUE NW ORONOCO, MN 55960

(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: SL36995016-0 On April 27, 2026, through April 29, 2026, 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 residents; four 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.	
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of	0 650		

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0 650	Continued From page 1 each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included evidence of orientation training for two of three unlicensed personnel (ULP-C, ULP-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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	0 650		

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0 650	Continued From page 2 situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C ULP-C was hired on August 9, 2024, to provide direct care services to residents of the facility. On April 27, 2026, at 12:00 p.m., the surveyor observed ULP-C administer medications to R1. ULP-D ULP-D was hired on March 10, 2025, to provide direct care services to residents of the facility. On April 28, 2026, at 7:40 a.m., the surveyor observed ULP-D administer medications to R4. ULP-C and ULP-D's employee files included several training and competency documents as well as an Educare training transcript (the licensee's online training system); however, ULP-C and ULP-D's employee files lacked evidence of the following required orientation training topics: - overview of Assisted Living statutes; - review of provider's policies and procedures; - handling of resident complaints, reporting of complaints, where to report; - consumer advocacy services; and - review of types of Assisted Living services the employee will provide and provider's scope of license On April 29, 2026, at 9:40 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the above listed orientation topics were covered in a separate type of training he provided at the time of hire and not assigned these topics	0 650		

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0 650	Continued From page 3 through Educare. He further stated he typically completed and signed a training record as evidence these topics were covered; however, he could not find them as part of ULP-C and ULP-D's employee files. The licensee's Personnel Records policy dated March 13, 2025, indicated the personnel record for each person will include: - Record of orientation; and - Record of all required training for unlicensed personnel and competency evaluations No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is	01060		

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01060	Continued From page 4 expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the Office of Ombudsman for Long-Term Care of an emergency relocation for one of one resident (R5). 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).	01060		

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01060	Continued From page 5 The findings include: R5 was admitted to the facility on May 8, 2020, with diagnoses including bipolar and schizoaffective disorder. R5's Service Plan dated January 6, 2025, indicated she received services including medication administration/management, behavior management, and safety checks. R5's progress notes included an entry on January 28, 2026, indicating R5 was emergently transferred to another (sister) facility due to concerns for R5's safety with a current housemate. The licensee failed to notify the Office of Ombudsman for Long-Term Care the resident had been relocated and had not returned to the facility within four days. On April 27, 2026, at 12:15 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he knew about the need to complete an emergency relocation notification and notify the Office of Ombudsman for Long-Term Care when a resident was hospitalized or if there was a catastrophe at the facility; however, had not considered the need to notify the Ombudsman if a resident was emergently transferred/moved to another (sister) facility. On April 28, 2026, at 1:49 p.m., the Ombudsman assigned to the licensee indicated she would expect notification by the licensee for an emergent move/relocation such as what occurred for R5.	01060		

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01060	Continued From page 6 No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01060		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of one of two unlicensed personnel (ULP-D) performing delegated tasks was	01440		

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01440	Continued From page 7 provided by the registered nurse (RN) within 30 calendar days after the date on which the individual began working for the licensee. 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: ULP-D was hired on March 10, 2025, to provide direct care services to residents of the facility. On April 28, 2026, at 7:40 a.m., the surveyor observed ULP-D administer medications to R4. ULP-D's employee file lacked evidence that the licensee's registered nurse (RN) completed a 30-day supervisory observation on performing delegated tasks. On April 29, 2026, at 9:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated she likely missed completing ULP-D's RN supervisory visit as she could not find record of it. The licensee's Supervision of Unlicensed Personnel policy dated March 13, 2025, indicated direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments, or assigned therapy tasks must be performed within 30 days (about 4 and a half weeks) after the person begins work for our facility and has been	01440		

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01440	Continued From page 8 trained and determined competent to perform all the tasks assigned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation	01530		

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01530	Continued From page 9 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 staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics within 160 hours of start date for two of two employees (ULP-C, ULP-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 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: ULP-C ULP-C was hired on August 9, 2024, to provide direct care services to residents of the facility. On April 27, 2026, at 12:00 p.m., the surveyor observed ULP-C administer medications to R1.	01530		

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01530	Continued From page 10 ULP-C's employee file/Educare training transcript printed April 28, 2026, indicated she completed one hour of mental health training labeled Mental Illness Response Strategies that was completed on April 7, 2026. ULP-D ULP-D was hired on March 10, 2025, to provide direct care services to residents of the facility. On April 28, 2026, at 7:40 a.m., the surveyor observed ULP-D administer medications to R4. ULP-D's employee file/Educare training transcript printed April 28, 2026, indicated she completed one hour of mental health training labeled Mental Illness Response Strategies that was completed on April 14, 2026. The licensee failed to ensure ULP-C and ULP-D completed the two hours of initial mental health training with the required content within 160 hours of employment including: - recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; - de-escalation techniques and communication; and - crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. On April 29, 2026, at 9:50 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated he was not familiar with the initial mental	01530		

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01530	Continued From page 11 health training requirements including the required topics and would assign the required training to all employees to be in compliance. LALD/RN-A further stated both ULP-C and ULP-D had worked greater than 160 hours since their hire dates. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications did not exceed their expiration date for two of four residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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).	01890		

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(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
01890	Continued From page 12 The findings include: On April 27, 2026, at 11:30 a.m., the surveyor and unlicensed personnel (ULP)-C reviewed the contents of the licensee's medication closet. The medication closet included the following expired medications: R1 -Albuterol 2 puffs orally four times daily as needed (PRN) for shortness of breath-the inhaler indicated an expiration date of December 31, 2025. R3 -Albuterol two puffs orally every hour hours PRN for shortness of breath-the expiration date was unreadable, and the inhaler had 204 puffs remaining; -loratadine 10 milligrams (mg) one tablet daily as needed for allergy symptoms, indicated an expiration date of November 2023, with 30 tablets remaining; and -antacid 500 mg, one tablet twice daily as needed for indigestion with expiration date of November 2023, and 20 remaining tablets On April 27, 2026, at 11:40 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated the PRN medications are not used often and the licensee missed checking the medications on a routine basis for expiration dates. The licensee's Storage of Medications dated March 13, 2025, indicated until the medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug,	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36995	A. BUILDING: _____ B. WING _____	04/29/2026

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01890	Continued From page 13 directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36995	A. BUILDING: _____ B. WING _____	04/29/2026

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01910	Continued From page 14 the required content for one of one discharged resident (R5). 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: R5's record indicated she began receiving assisted living services on May 8, 2020, and was discharged on January 28, 2026. R5's Service Plan dated January 6, 2025, included the service of medication management. R5's Medication Administration Record (MAR) dated January 2026, included one medication for allergies, three for psychosis, one antibiotic, one inhaler for shortness of breath, two supplements, one nasal spray, two for mild pain, one for nausea one for acid reflux, and two for depression. R5's progress note dated January 28, 2026, indicated R5 was transferred to another facility own/managed by the licensee due to safety concerns for R5. The licensee failed to document in the resident's record the disposition of his medications including the medication's name, strength, prescription number as applicable, quantity, date of disposition, and names of staff and other	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01910	Continued From page 15 individuals involved in the disposition. On April 27, 2026, at 12:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-B stated when R5 was moved to another (sister) facility, she just packed up R5's medications and brought them to the new facility and did not think to document the medications as a medication disposition. The licensee's Disposition or Disposal of Medication policy dated March 13, 2025, indicated drugs given to residents when the medication management services have been terminated including a resident's current medications that are secured or stored by our facility will be given to the resident, or the resident's representative except that the conditions listed below must be met before controlled medications. Staff will document in the residents' record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Sunset homes Assisted Living
9938 18TH AVENUE NW
Oronoco, MN 55960
Olmsted County
Parcel:

Phone:

License Info

License: HFID 36995

Risk:
License:
Expires on:
CFPM: Jane Nyamwaro
CFPM #: 16253; Exp: 7/15/2028

Inspection Info

Report Number: F1038261067
Inspection Type: Full - Single
Date: 4/28/2026 Time: 10:28:26 AM
Duration: 45 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Rochester District Office inspection report number F1038261067 from 4/28/2026

Jane Nyamwaro
Kitchen Manager

Rob Davis,
Public Health Sanitarian 2
rob.davis@state.mn.us