



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 3, 2025

Licensee

Options Gabriel Heights

1167 South Robert Street

West Saint Paul, MN 55118

RE: Project Number(s) SL28505016

Dear Licensee:

On April 21, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on January 8, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink that reads 'Tim Hanna'.

Tim Hanna, Supervisor

State Engineering Services Section

Health Regulation Division

Email: Tim.Hanna@state.mn.us

Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 18, 2025

Licensee

Options Gabriel Heights

1167 South Robert Street

West Saint Paul, MN 55118

RE: Project Number(s) SL28505016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 8, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28505	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER OPTIONS GABRIEL HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 1167 SOUTH ROBERT STREET WEST SAINT PAUL, MN 55118			
(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: SL28505016-0 On January 6, 2025, through January 8, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were ten residents; nine receiving services under the Assisted Living Facility license. An immediate correction order was identified on January 08, 2025, issued for, tag identification 0780. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 680	Continued From page 1	0 680			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; 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 (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. 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	0 680			

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0 680	Continued From page 2 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: The licensee's undated Emergency Preparedness plan, was reviewed and lacked the following: -process for EP collaboration. -policy and procedure addressing the role of facility under waiver declared by the Secretary in accordance with section 1135 of the ACT; -emergency Prep testing requirements On January 7, 2025, at 10:15 a.m., licensed assisted living director (LALD)-A stated she was aware of the requirements but the previous LALD was missing contents of the EP plan. The licensee's Disaster Planning and Emergency Preparedness policy dated July 17, 2022, indicated the licensee is in alignment with the facility's requirement to also comply with CMS Appendix Z. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 770 SS=F	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living facilities:	0 770			

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0 770	Continued From page 3 (1) public utilities must be available, and working or inspected and approved water and septic systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide sufficient natural drainage and is not subject to flooding; (4) all-weather roads and walks must be provided within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide safe all-weather roads and access to the facility for residents and emergency response vehicles. This had the potential to directly affect all residents, staff, emergency responders and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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). The findings include: On a facility tour on January 7, 2025, from 10:30 a.m. to 1:30 p.m., with licensed assisted living director (LALD)-A, it was observed the shared	0 770			

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0 770	Continued From page 4 parking lot and driveway has several large holes, cracks, and uneven surfaces. Driveways and roads should be smooth and even for the safety of residents, visitors, and responders to the facility. On January 7, 2025, at 11:30 a.m.; LALD-A stated, the driveway is shared with another property that is managed by a different management group, and they will work together with them to fix the deficiency. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 770			
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment 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;	0 780			

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0 780	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life and failed to keep the facility in compliance with the Minnesota Fire Code. This had the potential to directly affect all of the residents and staff. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). Findings include: On a facility tour on January 7, 2025, from 10:30 a.m. to 1:30 p.m., with licensed assisted living director (LALD)-A, it was observed that compliant emergency escape and rescue openings were not provided in all resident sleeping rooms. OCCUPIED RESIDENT SLEEPING ROOMS, Resident sleeping rooms in lower level units B1 and B2, emergency escape and rescue clear window opening measurements were 28 inches wide, 14 inches in height and only 392 square inches in openable area. The window was	0 780	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.		

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0 780	Continued From page 6 measured with LALD-A, and the surveyor present. The window did not meet the minimum requirements for total clear opening square inch area. Resident studio apartment in lower level B3, emergency escape and rescue clear window opening measurements were 28 inches wide, 14 inches in height and only 392 square inches in openable area. The window was measured with LALD-A, and the surveyor present. The window did not meet the minimum requirements for total clear opening square inch area. Resident sleeping rooms on first floor units, 101, 102,103, and 104, emergency escape and rescue clear window opening measurements were 28 inches wide, 18 inches in height and only 504 square inches in openable area. The window was measured with LALD-A, and the surveyor present. The window did not meet the minimum requirements for total clear opening square inch area. Resident sleeping rooms on second floor units, 201, 202, 203, and 204, emergency escape and rescue clear window opening measurements were 28 inches wide, 18 inches in height and only 504 square inches in openable area. The window was measured with LALD-A, and the surveyor present. The window did not meet the minimum requirements for total clear opening square inch area. It was explained to LALD-A, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening	0 780			

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0 780	Continued From page 7 area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. Windowsill height shall not be more than 48 inches from the floor to the clear opening. These deficient conditions were visually verified by LALD-A, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate. On the same facility tour with LALD-A., the surveyor made the following observations of non-compliance with current Minnesota Fire Code provisions. The 120-volt smoke alarm in all resident units was missing and a cover plate was covering wiring. Interconnected battery alarms were being used outside and inside the bedroom. Hard-wired safety devices are required to be maintained. Resident room, battery alarms must interconnect with required 120-volt smoke alarm outside of the room. Resident unit fire doors did not close and latch automatically. Fire doors are required to close and latch to reduce the spread of fire and smoke. These deficient conditions were visually verified by LALD-A accompanying on the tour. On January 7, 2025, at 11:30 a.m., LALD-A stated they understand the safety deficiencies. TIME PERIOD FOR CORRECTION: Two (2) day.	0 780			

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0 800	Continued From page 8	0 800			
0 800 SS=E	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 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 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). The findings include: On a facility tour on January 7, 2025, from 10:30 a.m. to 1:30 p.m., with licensed assisted living director (LALD)-A, it was observed.	0 800			

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0 800	Continued From page 9 The kitchen ceiling in unit 201 has large pieces of peeling paint near the light fixture. Peeling paint can cause the ceiling to be damaged and start to fail. The bathroom tub in unit 201 has enamel that is worn away. Loss of enamel can cause rusting, staining, chipping, rough surfaces, increased bacterial growth, and water leaks. On January 7, 2025, 2024, at 12:30 p.m., LALD-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff 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.	0 810			

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0 810	Continued From page 10 (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 staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on January 7, 2025, from 10:30 a.m. to 12:30 p.m., with licensed assisted living director (LALD)-A; surveyor observed the fire safety and evacuation plan (FSEP) was not located in a central location for all staff, visitors or residents' accessibility.	0 810			

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0 810	Continued From page 11 On January 7, 2025, LALD-A provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Options residential health", failed to include the following: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD stated that staff is all new and hired within the last three months. Longest employee had been there one year, a training was held in December of 2024. No other training documentation was provided. On January 7, 2025, at 12:30 p.m., LALD-A stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS: The licensee failed to conduct evacuation drills	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28505	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER OPTIONS GABRIEL HEIGHTS		STREET ADDRESS, CITY, STATE, ZIP CODE 1167 SOUTH ROBERT STREET WEST SAINT PAUL, MN 55118			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 12 for employees twice per year, per shift with at least one evacuation drill every other month. Record review of licensee's evacuation drill log, indicated evacuation drills were conducted on even months, only one drill for the overnight shift was recorded. No other documentation was provided. On January 7, 2025, at 12:30 p.m., LALD-A stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a	03090			

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03090	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 the residents). The findings include: On January 6, 2025, at 11:20 a.m. during the facility tour, no electronic monitoring signs were posted. Licensed assisted living director (LALD)-A stated they do not have any electronic monitoring and so do not have any signs posted. LALD-A stated she had heard different opinions on whether the posting was required and has not posted the sign. The licensee's electronic monitoring policy last revised August 1, 2021, indicated signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

Type: Full
Date: 01/07/25
Time: 09:00:00
Report: 1031251003

Food and Beverage Establishment Inspection Report

Page 1

Location:

Options Gabriel Heights
1167 South Robert Street
West St Paul, MN55118
Dakota County, 19

Establishment Info:

ID #: 0038259
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6514571446
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.

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

Nurse Evaluator: Tracey Fearon

Establishment has 11 private units.

All residents prepare their own food - no staff cooking, prep, or wash/sanitizing done.

No snacks or group meals provided.

If a resident doesn't want to cook, Mom's Meals or 1st Presbyterian is used.

RECOMMENDED: Place thermometers in all unit refrigerators and check temp (41F or below) during apartment checks.

Establishment using "R Task" for illness log. Fillable illness log sent with report.

Type: Full
Date: 01/07/25
Time: 09:00:00
Report: 1031251003
Options Gabriel Heights

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 Environmental Health inspection report number 1031251003 of 01/07/25.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Jackie Reiter
Kitchen Manager

Signed:_____ 
Chris Foster
Public Health Sanitarian III
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us