



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 14, 2025

Licensee
First Choice Assisted Living
2301 West 96th Street
Bloomington, MN 55431

RE: Project Number(s) SL35462016

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.

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,



Renee L. Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER FIRST CHOICE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2301 WEST 96TH STREET BLOOMINGTON, MN 55431			
(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: SL35462016-0 On January 6, 2025, through January 8, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents; four receiving services under the Assisted Living 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.		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680			

Minnesota Department of Health

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

TITLE

(X6) DATE

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0 680	Continued From page 1 (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 plan (EPP) with all the required content. This had the potential to affect all residents, employees and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when	0 680			

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0 680	Continued From page 2 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/Disaster Plan for [Licensee]" lacked the following required content: -documentation of participation in an annual full-scale exercise that was community based OR an annual, individual, facility-based functional exercise OR documentation if the facility experiences an actual emergency requiring activation of plan; -documentation of an additional annual exercise that may include: a second full-scale exercise that was community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analysis of the facility's response to and documentation of all drills, tabletop exercises and emergency events & revisions to EPP. On January 7, 2025, at 10:30 a.m., licensed assisted living director (LALD)-A stated they were unaware of the requirement to complete EPP drills. The licensee's Emergency Prepared and Testing and Training policy dated January 10, 2024 indicated the licensee "must conduct drills and exercises to test the emergency plan or participate in an actual incident that tests the plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			

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

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0 780	Continued From page 4 resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On a facility tour on January 7, 2025, from 2:30 p.m. to 5:30 p.m., with licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B. The surveyor asked LALD-A to initiate a test of the smoke alarms by pushing the hard-wired smoke alarm. Upon testing, it was found that the smoke alarms in the facility were not interconnected. Interconnected battery alarms were being used throughout the facility. Hard-wired safety devices are required to be maintained. Resident room, and other battery alarms must interconnect with required 120-volt smoke alarm. The 120-volt smoke alarm in all facility basement was over 10 years old. Smoke alarms should be replacement every 10 years or manufactures date. Resident room three and in the living room of the facility an extension cord was being used as permanent wiring. The overuse of extension cords may cause a fire, the use of a surge protector is authorized. Unoccupied sleeping room three, emergency escape and rescue clear window opening measurements were 38 inches wide, 17 inches in height and 642 square inches in openable area. The window was measured with LALD-A/CNS-B and the surveyor present. The window did not meet the minimum requirements for total clear	0 780			

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0 780	Continued From page 5 opening square inch area or the minimum of 20 inches in height. These deficient conditions were visually verified by LALD-A and CNS-B accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 780			
0 790 SS=D	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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	0 790			

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0 790	Continued From page 6 only occasionally). The findings include: On a facility tour on January 7, 2025, from 2:30 p.m. to 5:30 p.m., with licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B. The surveyor observed that the basement fire extinguisher was mounted over 6 feet off the ground. Fire extinguishers should be mounted three to five feet from the floor. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
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 7 (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. 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: The fire evacuation diagrams posted throughout the facility, no map or diagram was found in the fire safety and evacuation plan (FSEP). Maps/diagrams should be located in the FSEP to aid first responders.	0 810			

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0 810	Continued From page 8 FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Care providers", dated September 2022, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. Licensed assisted living director (LALD)-A, and clinical nurse supervisor (CNS)-B lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES.	0 950			

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0 950	Continued From page 9 You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to identify a designated representative or document that the resident declined to designate a representative for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	0 950			

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0 950	Continued From page 10 R1's service plan, dated October 1, 2024, indicated R1 received services including assistance with activities of daily living (ADLs), housekeeping, and medication management. R1's contract, dated May 5, 2024, lacked documentation that R1 was given the opportunity to designate a representative and the required verbiage notifying R1 of their "right to designate a representative for certain purposes." During an interview on January 7, 2025, at 10:30 a.m., licensed assisted living director (LALD)-A stated R1's record lacked the required verbiage related to identifying a designated representative. LALD-A stated the required verbiage was missing from all residents' contracts because they were not aware the verbiage was required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
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	01060			

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01060	Continued From page 11 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 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 provide a written notice with required content related to an emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01060			

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01060	Continued From page 12 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: R1's diagnoses included diabetes. R1's service plan, dated October 1, 2024, indicated R1 received services including assistance with activities of daily living (ADLs), housekeeping, and medication management. R1's record included a hospital note dated September 16, 2024, indicating R1 was admitted to the hospital on September 12, 2024. A nursing assessment dated September 17, 2024, indicated R1 returned from the hospital on September 17, 2024. R1's record lacked documentation of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for Office of Ombudsman for Long-Term Care (OOLTC), - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35462	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/08/2025
NAME OF PROVIDER OR SUPPLIER FIRST CHOICE ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 2301 WEST 96TH STREET BLOOMINGTON, MN 55431			
(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
01060	Continued From page 13 resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. The record further lacked documentation the notice was provided to the OOLTC for a relocation lasting four days or longer. On January 7, 2024, at 11:00 a.m., licensed assisted living director (LALD)-A stated a written notice had not been provided with the required content. LALD-A stated he was not aware of the requirement to provide an emergency relocation notice to R1. The licensee's undated Notice of Emergency Relocation policy indicated the above information would be completed and provided to the resident and, the OOLTC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			



Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 01/07/25
Time: 12:00:48
Report: 1050251006

Food and Beverage Establishment Inspection Report

Page 1

Location:

First Choice Assisted Living
2301 West 96th Street
Bloomington, MN55431
Hennepin County, 27

Establishment Info:

ID #: 0038844
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529559749
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.

Surface and Equipment Sanitizers

Hot Water: = at 160F Degrees Fahrenheit
Location: Diswasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding/Milk
Temperature: 41F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Cold Holding/Lettuce
Temperature: 40F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

Process/Item: Cold Holding/Cheese
Temperature: 40F Degrees Fahrenheit - Location: Reach-In Cooler
Violation Issued: No

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

Announced inspection completed by MDH Andrew Spaulding and director Nawal Hirsi on 1/7/25.

All violations were discussed with person in charge at time of inspection.

Discussed staff illness policy, final cook temperatures, cooling, temperature control, cleaning, produce washing, date marking, food storage, ware washing, sanitizer use, hand washing, glove use, and food handling procedures, recalls.

Type: Full
Date: 01/07/25
Time: 12:00:48
Report: 1050251006
First Choice Assisted Living

Food and Beverage Establishment Inspection Report

Page 2

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 1050251006 of 01/07/25.

Certified Food Protection Manager Nawal Yusuf Hirsi

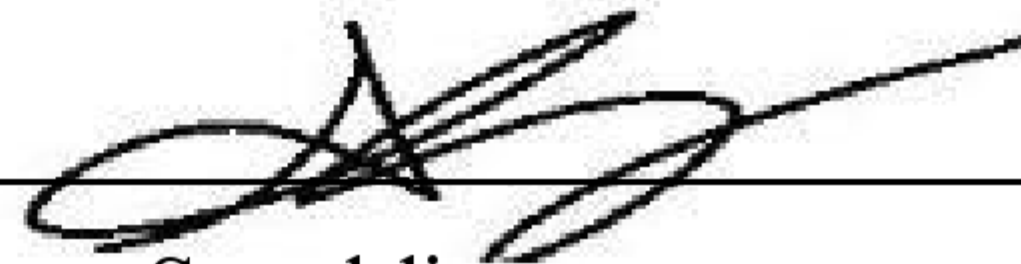
Certification Number: FM55064 Expires: 12/19/27

Inspection report reviewed with person in charge and emailed.

Signed: _____

Nawal Yusuf Hirsi
Director

Signed: _____


Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us