Electronically Delivered

July 24, 2023

Licensee
Madonna Meadows Of Rochester
3035 Salem Meadows Drive Southwest
Rochester, MN 55902

RE: Project Number(s) SL30704015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 29, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The 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 . . ."

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 may be 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.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment.
The MDH may impose 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 MDH 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 (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, the following fines are assessed pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 the MDH within 15 calendar days of the correction order receipt date.

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the MDH within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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 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: 651-281-9796

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30704	A. BUILDING: _____ B. WING _____	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA MEADOWS OF ROCHESTER	3035 SALEM MEADOWS DR SW ROCHESTER, MN 55902

(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: SL30704015-0 On June 26, 2023, through June 29, 2023, 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, there were 60 active residents; 58 receiving services under the Assisted Living with Dementia Care 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 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. 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 subd. 1, 2, and 3.	
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) Minimum Requirements (13) offer to provide or make available at least the	0 485		

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0 485	Continued From page 1 following services to residents: (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: (A) menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post a menu a week in advance that was made available to all residents. This had the potential to affect all residents in the memory care unit. 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 potential to affect a large portion or all of the residents). The findings include: On June 27, 2023, at 8:30 a.m. during observation of the breakfast meal service in the	0 485		

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0 485	Continued From page 2 memory care unit, two menus were found posted on bulletin boards in the hall leading to the dining room. One menu was dated February 27, 2023, through March 5, 2023, and the other was dated June 5, 2023, through June 11, 2023. On June 27, 2023, at 12:00 p.m. culinary manager (CM)-H stated the practice was for the memory care staff to ask the kitchen staff for a four week cycle menu and post it in the memory care unit. He stated he would post an updated menu and re-educate staff to this practice. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 485		
0 510 SS=F	144G.41 Subd. 3 Infection control program (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. (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. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of two	0 510		

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0 510	Continued From page 3 unlicensed personnel (ULP-D) between resident contact, medication administration and meal service. This had the potential to affect all residents. 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). The findings include: On June 27, 2023, at 7:45 a.m. ULP-D was observed to don gloves prior to setting up medications for R3. ULP-D opened the medication cupboard in R3's bathroom, referenced the electronic medication administration record (eMAR) on her tablet/phone, set up medications for administration, went to the family room where R3 was sitting in her chair, administered oral medications and administered a topical cream to R3's forearms. ULP-D then returned to R3's room/medication cupboard to return the topical cream to the medication cabinet, documented the medication administration on her tablet/phone, locked the medication cupboard and removed her gloves. ULP-D was then observed to go directly to R2's room to set up medications. ULP-D failed to wash her hands prior to donning clean gloves and entering R2's medication cupboard to set up medications. ULP-D set up R2's oral medications, locked the medication cupboard and administered oral medications with the same gloves. Following documentation and locking R2's medication cupboard, ULP-D removed her gloves	0 510		

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0 510	Continued From page 4 and went to the family room and assisted several residents to the memory care dining room. ULP-D was observed to provide direct hands on contact with residents as she assisted them to the dining room, either by assisting with their walkers, or hands on contact with their wheelchairs. At 8:20 a.m., ULP-D donned clean gloves and assisted with serving juices/coffee/milk to several residents in the dining room. ULP-D assisted with the meal cart and delivered several meals to residents in the dining room. ULP-D was observed to don clean gloves as she assisted feeding a resident in the dining room. Following breakfast, ULP-D was observed to remove gloves and assist several residents to their rooms or the family room. During the period of observation from medication set up/administration through breakfast, ULP-D was not observed to perform hand hygiene between hands on contact between residents or in between glove use. On June 27, 2023, at 10:35 a.m. clinical nurse supervisor (CNS)-B stated her expectation was for staff to use proper hand hygiene between resident cares, medication administration and following and in between use of gloves. CNS-B stated she would provide follow up education to staff. The licensee's handwashing policy dated 2022, indicated "When Hands Should be Washed. Hand washing shall be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a client b. If moving from a contaminated-body site to a clean-body site during client care c. After contact with environmental surfaces or	0 510		

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0 510	Continued From page 5 equipment in the immediate vicinity of the client d. After removing gloves or gowns e. Before eating and after using a restroom removal of gloves and washing hands after touching contaminated surfaces." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

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0 810	Continued From page 6 least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop fire safety and evacuation plans with the required elements; failed to provide the required training frequency for residents on fire safety and evacuation; and failed to meet the evacuation drill frequency requirements. 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 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). Findings include: On June 28, 2023, between 9:30 a.m. and 11:00 a.m., survey staff toured the facility with maintenance (M)-J. During the facility tour, survey staff observed that that posted evacuation maps did not identify the location and number of resident sleeping rooms. M-J verified this deficient condition during the facility tour. On June 28, 2023, at approximately 11:00 a.m.,	0 810		

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0 810	Continued From page 7 records were provided for review. Records were reviewed by survey staff on June 28, 2023, between 11:00 a.m. and 12:45 p.m. Record review of the fire safety and evacuation plans indicated that the licensee had not identified the location and number of resident sleeping rooms in the plans. Record review of the available documentation did not support that resident training on the proper actions to take in the event of a fire to include movement, evacuation, or relocation had been completed annually. A resident training record was provided that was completed when the resident moved in. The licensed assisted living director (LALD)-A explained that residents were trained when they moved in and will be trained twice a year moving forward. Record review of documented evacuation drills indicated that evacuation drills for employees had not been completed in September, October, and December of 2022 and January 2023. No additional evacuation drill records were provided. The evacuation drill frequency requirement of at least one evacuation drill every other month was not met. On June 28, 2023, at approximately 12:45 p.m., the LALD-A verified these deficient conditions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including	0 820		

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0 820	Continued From page 8 assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. 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. This had the potential to directly affect all 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 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). On June 28, 2023, between 9:30 a.m. and 11:00 a.m., survey staff toured the facility with maintenance (M)-J. During the facility tour, survey staff observed space heaters in dementia care resident sleeping rooms B4 and B7. This deficient condition was verified by M-J accompanying on the facility tour.	0 820		

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0 820	Continued From page 9 TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
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 one of one unlicensed personnel (ULP-F) was supervised by a registered nurse (RN) within 30 days after providing delegated tasks. This practice resulted in a level two violation (a	01440		

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01440	Continued From page 10 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-F began providing assisted living services for the licensee's residents on March 3, 2023. The employee's records lacked evidence an RN conducted direct supervision of ULP-F within 30 days of performing delegated tasks. On June 27, 2023, at 7:55 a.m. ULP-F was observed to administer morning medications to R5. ULP-F's employee record lacked evidence of direct supervision within 30 days after performing delegated tasks. On June 29, 2023, at 11:53 a.m. clinical nurse supervisor (CNS)-B confirmed the 30-day supervision was not completed. The licensee's Supervision of Unlicensed Personnel policy undated indicated that direct supervision of ULP providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for the community and has been trained and determined to be competent in performing assigned tasks. No further information was provided.	01440		

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01440	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care 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 employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia 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 staff received required dementia care training in the required time frame for one of one employee (unlicensed personnel (ULP)-F). This had the potential to affect all 60 residents. 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	01540		

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01540	Continued From page 12 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The finding include: ULP-F started employment on March 3, 2023. On June 27, 2023, at 7:55 a.m. ULP-F was observed to administer morning medications to R5. ULP-F's record indicated the employee did not complete eight hours of training in dementia care within 80 hours of the employee's start date. The record indicated ULP-F completed only 7.25 hours of dementia training as of June 29, 2023. On June 29, 2023, at 11:53 a.m., clinical nurse supervisor (CNS)-B stated ULP-F was not in compliance with dementia care training as required and completed 7.25 hours as of June 29, 2023. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.	01620		

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01620	Continued From page 13 (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for two of four residents (R2, R5). In addition, the RN failed to complete a 14-day assessment timely for one of one resident (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 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:	01620		

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01620	Continued From page 14 R2 R2's service plan dated June 16, 2023, indicated R2 received services to include medication administration, assistance with bathing, showering, dressing, toileting, and standby assistance or wheelchair assistance for ambulation. R2's last three Comprehensive Assessments were requested. Resident Evaluations dated February 23, 2023, and June 16, 2023, were provided. The June 16, 2023, assessment was 114 days from the previous assessment date, exceeding 90 calendar days. R5 R5's service plan dated October 19, 2022, indicated R5 received services to include medication administration, assistance with bathing, blood glucose checks, housekeeping, and laundry. R5's last three comprehensive assessments were requested. Resident evaluations dated October 19, 2022, and January 13, 2023, were provided. At the time of survey on June 26, 2023, it marks 164 days from the previous assessment date, exceeding 90 calendar days. On June 28, 2023, at 2:50 p.m. clinical nurse supervisor (CNS)-B confirmed the last comprehensive assessment was completed January 13, 2023, confirming the last assessment exceeded the 90 calendar days as required. R3 R3's move in date and start of services was May 5, 2023. R3's service plan dated May 5, 2023, indicated	01620		

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01620	Continued From page 15 R3 received services to include medication administration, assistance with bathing/showering, and verbal cues for dressing and personal cares. R3's comprehensive assessments were requested. R3's initial Resident Evaluation was dated May 5, 2023, and her 14-day Resident Evaluation was dated June 28, 2023, (54 days after R3's start of services). On June 28, 2023, at 3:00 p.m. CNS-B stated she had completed R3's 14-day assessment on June 28, 2023, and noted it had not been completed within 14 days after the start of services as required. Additionally, CNS-B stated R2's 90 day comprehensive assessment was completed past the 90 day due date. The licensee's Initial and On-going Assessments of Residents policy dated August 1, 2021, noted a RN would complete a 14-day assessment up to 14 days after the start of services, and an Ongoing assessment would be completed periodically but no less than every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;	01650		

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01650	Continued From page 16 (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident service plans included all the required content for four of four residents (R2, R3, R4, 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 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).	01650		

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01650	Continued From page 17 The findings include: R2 R2 began receiving services on April 2, 2015, with diagnoses including Alzheimer's disease (a progressive deterioration of the brain), anxiety disorder, seizure disorder, and depression. R2's Service Plan dated June 16, 2023, indicated R2 received services to include medication administration, assistance with bathing, showering, dressing, toileting, and standby assistance or wheelchair assistance for ambulation. On June 27, 2023, at 7:50 a.m. unlicensed personnel (ULP)-D was observed to provide medications to R2, and assisted R2 with repositioning while in bed. R2's service plan lacked the following: -the fees for services R3 R3 began receiving services on May 5, 2023, with diagnoses including unspecified dementia (brain deterioration without a known cause), history of traumatic subarachnoid hemorrhage with loss of consciousness (history of a brain bleed with loss of consciousness), and history of falls. R3's service plan dated May 5, 2023, indicated R3 received services to include medication administration, assistance with bathing/showering, and verbal cues for dressing and personal cares. On June 27, 2023, at 7:45 a.m. ULP-D was observed to provide oral and topical medications	01650		

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01650	Continued From page 18 to R3. R3's service plan lacked the following: - the proper identification of staff or categories of staff who will provide the services. In the section of the service plan labeled Nurse Management of Medication/Treatments the licensee indicated the "resident assistant" (ULP) provided the service of medication management for staff supervision, when this was a licensed staff role/responsibility. On June 28, 2023, at 3:00 p.m. clinical nurse supervisor (CNS)-B stated she was new to her role and had just yesterday learned about recognizing the service fee portion of the service plan and had missed including it with R2's service plan. Additionally, regarding the service plan section identifying which staff manage medication management, CNS-B stated Matrix (the computer application used for medical records) auto populates each of these fields with "resident assistant" (unlicensed personnel) and she had not caught this to edit it to reflect this task was managed by the registered nurse. R4 R4 began receiving services on May 30, 2023, with diagnoses including essential hypertension, anxiety, and acute respiratory disease. R4's service plan dated June 26, 2023, indicated R4 received services to include medication administration, assistance with bathing, showering, and wound treatment. R4's service plan lacked the following: -the fees for services - the proper identification of staff or categories of staff who will provide the services. In the	01650		

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01650	Continued From page 19 Category of Assessment of the service plan the resident need of Initial-RN ONLY Face to Face indicated the "resident assistant" ULP provided the service. In the Category of Assessment of the service plan the resident need of 14-day reassessment-RN face to face indicated the "resident assistant" provided the service. In the Category of Assessment of the service plan the resident need of Nurse Management of Medication/Treatments of the service plan the resident need of managing medications for staff to supervise or administer-simple 0-9 different medications using (preferred or house) pharmacy indicated the "resident assistant" (ULP) provided the service of medication management for staff supervision, when these were licensed staff role/responsibility. R5 R5 began receiving services on June 6, 2013, with diagnoses including essential hypertension, gastroesophageal reflux, congestive heart failure, and diabetes. R5's service plan dated October 19, 2022, indicated R5 received services to include medication administration, bathing set up, blood glucose checks, laundry, and housekeeping. On June 27, 2023, at 7:55 a.m. ULP-F was observed to administer morning medications to R5. R5's service plan lacked the following: - the proper identification of staff or categories of staff who will provide the services. In the Category of Assessment of the service plan the resident need of 90-day reassessment indicated the "resident assistant" (ULP) provided the service when this was a licensed staff	01650		

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01650	Continued From page 20 role/responsibility. On June 28, 2023, at 2:50 p.m. CNS-B stated R4's service plan dated June 26, 2023, included the information above and R5's service plan dated October 19, 2022, included the information above. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan would include a description of the services to be provided, the fees for services (including any changes to the provider's fee for services), and the frequency of each service, according to the resident's current review or assessment and resident preferences, and the identification of the type staff (RN/LPN, Therapists, Unlicensed Personnel, etc.) that will provide the services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident.	01750		

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01750	Continued From page 21 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-F), followed appropriate medication administration procedures during a medication pass. 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, 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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-F had a hire date of March 3, 2023, and provided direct care services including medication administration, to the licensee's residents. On June 27, 2022, at 7:55 a.m. the surveyor observed ULP-F administer morning medications to R5. ULP-F performed hand hygiene, punched eleven medications out of the punch pack for the correct day into a medication cup and gave the medications to R5. ULP-F was questioned why the number of medications didn't match up with the number of medications due at 8:30 a.m., which was three medications. ULP-F stated she set up the 8:00 a.m. medications and the 8:30 a.m. medications but already charted the 8:00 a.m. medications as given. ULP-F stated she did this because she's been getting behind with her charting.	01750		

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01750	Continued From page 22 ULP-F's employee record indicated he had been trained on medication administration and passed a competency evaluation with a registered nurse on April 6, 2023. On June 27, 2022, at 10:03 a.m., clinical nurse supervisor (CNS)-B stated the expectation of a medication administration record would be followed and chart late if needed, versus charting medications as given prior to medications actually given. The licensee's Medication, Treatment, and Therapy Administration policy dated August 1, 2021, indicated the staff who administer medications would ensure documentation of a medication reminder, medication assistance, medication administration, treatment, or therapies would be completed immediately after that task has been performed No further information was provided. Time period for correction: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet	01760		

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01760	Continued From page 23 the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered as ordered for one of four residents (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). The findings include: R3 began receiving services under the licensee's Assisted Living with Dementia Care license on May 5, 2023. R3's diagnoses included unspecified dementia (brain deterioration without a known cause), history of traumatic subarachnoid hemorrhage with loss of consciousness (history of a brain bleed with loss of consciousness), and history of falls. R3's Service Plan dated May 5, 2023, indicated R3 received medication administration. R3's signed medication orders dated May 4, 2023, included orders for: -acetaminophen 500 mg (milligrams), two tablets	01760		

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01760	Continued From page 24 three times daily for mild pain; -lidocaine external patch 4%, apply to right lower back topically (on the skin), one time daily for pain and remove per schedule (on for 12 hours, off for 12 hours); -Triamcinolone Acetonide external cream 0.1%, apply to upper extremities topically two times daily for skin care; and -Zyrtec Allergy tablet, give one tablet by mouth two times a day for allergies. On June 27, 2023, at 7:45 a.m. unlicensed personnel (ULP)-D was observed to set up and administer medications for R3. At 9:15 a.m., the surveyor and ULP-D reviewed the contents of the medication cupboard in R3's bathroom. The surveyor noted a box of lidocaine 4% patches with a label that read "apply one patch every day, on for 12 hours and off for 12 hours." When asked about when these patches are used, ULP-D stated she did not know anything about them and they (the patches) did not appear on R3's medication administration record (MAR). On June 27, 2023, at 12:00 p.m. the surveyor asked clinical nurse supervisor (CNS)-B about R3's lidocaine patches noted in her medication cupboard, CNS-B stated she was not sure and needed to look into it. On June 28, 2023, at 2:00 p.m. the licensee provided R3's MAR dated June 2023. The MAR indicated R3 received medications to include: -acetaminophen tablet, 500 mg, two tablets three times daily for pain with a start date May 5, 2023-open ended. The MAR indicated staff initials which indicated medication administration for the dates of June 1-26, 2023, for the times to include 8:00 a.m., 2:00 p.m., and 8:00 p.m. and then for June 27, 2023, at 8:00 a.m.	01760		

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01760	Continued From page 25 -triamcinolone cream 0.1%, one application topically to the upper extremities two times a day for skin care, with a start dated of May 5, 2023-open ended. The MAR included staff initials which indicated medication administration for the dates of June 1-26, 2023, for the times to include 8:00 a.m. and 8:00 p.m. and for June 27, 2023, at 8:00 a.m. -Zyrtec tablet, 10 mg, administer one tablet twice daily for allergies, with a start date of June 27, 2023-open ended. The MAR indicated an "X" on each of the dates from June 1-26, 2023. -lidocaine external patch 4%, one patch to effected area at 8:00 a.m. and leave on for 12 hours. Remove patch at 8:00 p.m. and leave off for 12 hours for low back pain, with a start date of June 27, 2023-open ended. The MAR indicated an "X" on each of the dates from June 1-26, 2023. The licensee failed to enter R3's Zyrtec and lidocaine patches into the MAR and failed to administer these medications since her admission date of May 5, 2023. On June 28, 2023, at 3:05 p.m. the surveyor re-inquired about the status of R3's lidocaine patch supply and noted it was now added to R3's MAR and had started on June 27, 2023. CNS-B stated she had reviewed orders received and found the lidocaine patches and Zyrtec had not been entered into the MAR, nor started as prescribed at the time R3 was admitted on May 5, 2023. CNS-B stated the surveyor's report of the lidocaine patch was the only communication she had received and she expected the ULP to notify her or another nurse with medication questions or concerns. CNS-B stated she had completed a medication error and was reviewing with the licensee's team, the criteria for filing a MAARC report.	01760		

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	30704	A. BUILDING: _____ B. WING _____	06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADONNA MEADOWS OF ROCHESTER	3035 SALEM MEADOWS DR SW ROCHESTER, MN 55902

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01760	Continued From page 26 On June 29, 2023, at 9:40 a.m. registered nurse (RN)-C stated she had filed a MAARC report for R3's medications not received since her admission date of May 5, 2023. The licensee's Medication/Treatment Orders-Receiving, Implementing, Renewal, and Re-ordering policy dated 2021, indicated a licensed nurse, licensed therapist or pharmacist ensure that medications and treatment orders (either in writing, verbally, or electronically) by an authorized provider are transcribed into the medical record. Upon receipt of a medication and/or treatment order from the authorized provider, whether it is a new order or a change in an existing order, the licensed nurse will take action to implement the order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to the manufacturer's recommendations in one of one medication refrigerator.	01880		

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01880	Continued From page 27 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: On June 27, 2023, at 7:55 a.m., the surveyor reviewed the medication refrigerator located in R5's room with unlicensed personnel (ULP)-F. The refrigerator contained the following medications: - one opened NovoLog FlexPen insulin pen (short acting insulin used to reduce blood sugar); - three opened Lantus SoloStar insulin pens (long acting insulin used to reduce blood sugar); and - one opened Victoza pen (non-insulin that lowers blood sugar) The temperature of the refrigerator was observed to be 40 degrees Fahrenheit (F). ULP-F confirmed the temperature of the refrigerator and stated the opened insulin pens were stored in the resident's room refrigerator. ULP-F stated unopened insulin pens are in the nurse's office in the medication refrigerator. On June 27, 2023, at 10:10 a.m. clinical nurse supervisor (CNS)-B confirmed all unopened insulin should be in the nurse's office refrigerator, and stored per manufacturer's instruction. Opened insulin should be stored in the resident's locked medication cabinet and stored per manufacturer's instruction.	01880		

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01880	Continued From page 28 The manufacturer guidelines for NovoLog FlexPen dated March 2023, indicated once NovoLog FlexPen is punctured, it should be kept at room temperature (below 86°F). The manufacturer guidelines for Lantus Solostar pen dated August 2022, indicated after its first use, don't refrigerate the Lantus SoloStar pen. Keep it at room temperature only (below 86°F). The manufacturer guidelines for Victoza pen dated January 2010, indicated the medication should be stored at a temperature between 59ºF to 86ºF and kept dry. The licensee's Storage of Medications policy dated reviewed March 3, 2022, indicated medications would be stored per manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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	01890		

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01890	Continued From page 29 review, the licensee failed to monitor for expired controlled substances for three of three residents (R6, R7, R8). Additionally, the facility failed to label time sensitive medications with a date when opened for one of one resident (R5) who received medication management services. 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 June 27, 2023, at 10:10 a.m. the surveyor and clinical nurse supervisor (CNS)-B reviewed the controlled substances housed in locked tackle boxes in the nurse's office located on the second floor of the facility. The contents of the medication supply were found to include expired medications, and a medication with no noted expiration date as follows: R6 -Tramadol 50 mg (milligrams) used for pain. The label indicated an expiration date of April 12, 2022. The narcotic record indicated R6 last received this medication on August 3, 2022. There were 27 tablets remanding in the bottle. R7 -oxycodone 5 mg used for pain, with a fill date listed as August 19, 2021, with no indicated expiration date. There was no record to indicate when R7 last received this medication. There	01890		

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01890	Continued From page 30 were five tablets remaining in the bottle. Orders received by the licensee did not include an active order for oxycodone. R8 -haloperidol 5 mg used for agitation, restlessness, nausea, indicated an expiration date of December 2021. R8's record did not indicate when she last received this medication. There were five tablets remaining in the bottle. At the time, CNS-B confirmed the above concerns and stated she had just recently started with the licensee and had not yet reviewed the controlled medication supply or process for controlled substance storage in the nurse's office, but it would be her responsibility to do so moving forward. R5 On June 27, 2023, at 7:55 a.m. ULP-F was observed to assist R5 with Novolog FlexPen (short-acting insulin used to reduce blood sugar) administration. ULP-F confirmed to no open date on pen. ULP-F stated she usually puts an open date on the pen, and was trained to so. R5's Novolog FlexPen lacked a date to indicate when staff opened it, or when it would expire. On June 27, 2023, 10:10 a.m. CNS-B confirmed all insulin pens should be dated when opened. The manufacturer guidelines for Novolog FlexPen dated March 2023, indicated once a cartridge or Novolog FlexPen was punctured, it should be kept at room temperature (below 86°F). The licensee's Storage of Medications policy dated August 1, 2021, indicated until the medication is set up for immediate or later	01890		

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01890	Continued From page 31 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, directions for use, client's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. This had the potential to 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	02140		

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02140	Continued From page 32 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). The findings include: The licensee held an assisted living with dementia care license effective August 1, 2022, through August 31, 2023. During the entrance conference on June 26, 2023, at 11:30 a.m. clinical nurse supervisor (CNS)-B stated she was new to her role and was the person assigned to oversee the staff training in the care of residents with dementia. CNS-B stated she had received some general dementia training, but had not completed the required certificate training and was working toward completion. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	02140		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations;	02170		

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02170	Continued From page 33 (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (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. (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: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and develop an individualized activity plan for two of two residents (R2, R3) who received services under an assisted living with dementia care license. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02170		

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02170	Continued From page 34 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). The findings include: The licensee held an assisted living with dementia care license effective August 1, 2022, through August 31, 2023. R2 R2's diagnoses included Alzheimer's disease (a progressive deterioration of the brain). R2's record included a Person Centered Wellness Questionnaire dated June 16, 2023, but was not completed. R2's record lacked an evaluation of the following: - 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. In addition, R2's record lacked the development of an individualized activity plan. R3 R3 diagnoses included unspecified dementia (brain deterioration without a known cause). R3's record contained two Person Centered Wellness Questionnaires dated May 5, 2023, and June 28, 2023, but they were not completed.	02170		

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02170	Continued From page 35 R3's record lacked an evaluation of the following: - 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. In addition, R3's record lacked the development of an individualized activity plan. On June 28, 2023, at 3:00 p.m. clinical nurse supervisor (CNS)-B stated the licensee had a new activities director and he was just getting started/oriented to his role. CNS-B stated she had started completing some of the person centered wellness questionnaires for the residents of the memory care unit but either had not gotten to some or had not finished others. Regarding the activities assessment and plan for R2 and R3, CNS-B stated they were both incomplete. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

Minnesota Department of Health
Food, Pools, Lodging
18 Woodlake Dr. SE
Rochester
507-206-2700

Type: Full
Date: *06/27/23*
Time: 10:18:46
Report: 8074231127

Food and Beverage Establishment Inspection Report

Location:
Madonna Meadows Of Rochester
3035 Salem Meadows Dr Sw
Rochester, MN55902
Olmsted County, 55

Establishment Info:
ID #: 0039370
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5072525400
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 162 Degrees Fahrenheit
Location: internal dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 165 Degrees Fahrenheit - Location: burger
Violation Issued: No

Process/Item: Cooking
Temperature: 170 Degrees Fahrenheit - Location: soup
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: lettuce, tomato
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: butter
Violation Issued: No

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

Type: Full
Date: *06/27/23*
Time: 10:18:46
Report: 8074231127
Madonna Meadows Of Rochester

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 8074231127 of 06/27/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____
Establishment Representative

Signed:_____
Andrea Kieffer

507-206-2721
andrea.kieffer@state.mn.us