Electronically Delivered

August 23, 2024

Licensee
Sabainah Healthcare Inc
1816 Yellowstone Trail
Brooklyn Park, MN 55444

RE: Project Number(s) SL34953015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 1, 2024, 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34953	A. BUILDING: _____ B. WING _____	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SABAINAH HEALTHCARE INC	1816 YELLOWSTONE TRAIL BROOKLYN PARK, MN 55444

(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 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: SL#34953015-0 On July 29, 2024, through August 1, 2024, 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 2 residents receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 30, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual	0 650		

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0 650	Continued From page 2 contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document a completed TB baseline screening at time of hire for one of one employee (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	0 650		

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0 650	Continued From page 3 ULP-D was hired on December 8, 2022. ULP-D's employee record lacked documentation of a completed TB baseline screening at time of ULP-D's hire. On July 29, 2024, at 2:00 p.m., licensed assisted living director (LALD)-A stated ULP-D received TB baseline screening at time of hire but has no record of a completed TB screening for ULP-D at time of hire. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated baseline screening is completed at time of hire for all direct care providers and testing results will be kept in each employee medical file. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and the CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment. The guidelines also indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		

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0 680	Continued From page 4	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680		

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0 680	Continued From page 5 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 is 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 July 29, 2024, at approximately 12:00 p.m., licensed assisted living director (LALD)-A provided a binder and stated the contents were the licensee's EPP. The licensee's EPP undated, lacked an individualized plan to include all the required content below: -missing annual review; -missing resident quarterly review; -development of all policies/procedures (P/P) based on hazard and vulnerability assessment (HVA); -development of communication plan; and -emergency procedure training and testing program; On July 29, 2024, at approximately 1:00 p.m., LALD-A acknowledged the licensee's EPP lacked the above listed required content. LALD-A stated the licensee's EPP was a work in progress and was not aware of all the requirements of Appendix Z. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee's EPP would have an identified EEP in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services.	0 680		

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0 680	Continued From page 6 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
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 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	0 810		

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0 810	Continued From page 7 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on document and record review and interview, the licensee failed to provide all required contents and the required employee fire evacuation drills. This has the potential to directly affect the safety of visitors, staff, and 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 July 30, 2024, at 5:37 p.m., survey staff received an email from the licensed assisted living director (LALD)-A with three PDF attachments of the home ' s fire safety and evacuation plan, training documentation, and related policies, and evacuation drill records. On July 31, 2024, at approximately 2:00 p.m. a document and record review and teleconference interview with the LALD-A indicated the following: -Document review of the available documentation revealed the licensee lacked specific fire protection procedures for residents. There were no evacuation procedures provided for review that residents should follow in case of a fire or similar emergency. The LALD-A concurred with	0 810		

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0 810	Continued From page 8 the finding and stated that they will revise their policy document, Responsibilities of Patients (undated), to be specific to include the home ' s fire protection procedures for residents. -Record review of the available documentation revealed the licensee did not indicate the employee evacuation drills had not been performed for their morning work shift (8:00 a.m. to noon) for the calendar years 2023 and 2024 to date. Survey staff explained employee evacuation drills must be performed twice per year per shift and at least once every other month as required. During the interview, the LALD-A verified that the evacuation drills had not been performed for the morning shift when the LALD-A and his wife worked the morning shift. The LALD-A further stated that they had covered the drills for the other two later shifts. The LALD-A acknowledged the above deficient findings during the interview and stated that they would make the necessary corrections. No further information was provided. TIME-PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970		

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0 970	Continued From page 9 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. 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 July 29, 2024, at approximately 3:00 p.m., licensed assisted living director (LALD)-A provided a resident's (R2) current Assisted Living Contract and indicated the same contract was used by the licensee for all residents who lived in the facility. The licensee's Assisted Living Contract, dated October 14, 2021, on page 3, included a section titled Liability of Resident and Management Damage or Injury to Resident or his/her Property and read, "Management is not responsible for damages or injury that is done to resident or his/her property ... while the person or property was in or on the apartment and/or common areas." On July 29, 2024, at approximately 3:15 p.m., LALD-A acknowledged the licensee's assisted	0 970		

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0 970	Continued From page 10 living contract included a waiver of liability for health and safety or personal property of the resident. LALD-D indicated the liability waiver would need to be removed from all contracts and resigned by all residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 970		
01620 SS=F	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. (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.	01620		

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01620	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed comprehensive assessments to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted on August 17, 2021. R2's Nurse Reassessment Visit record dated May 28, 2024, was a two-page document identified by RN-C as R2's 90-day RN assessment completed by RN-C. The assessment was marked in multiple areas with a check that read "no change" (NC) and lacked any data in those areas about R2's physical or cognitive assessment completed by RN-C. R2's assessment failed to be developed and address the required content per Minnesota Administrative Rule 4659.0140 Subp. 2. B. (3). On July 29, 2024, at 3:00 p.m., RN-C stated the licensee performed a RN reassessment once a year that included all the elements of the uniform assessment tool, then used the two-page RN	01620		

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SABAINAH HEALTHCARE INC	1816 YELLOWSTONE TRAIL BROOKLYN PARK, MN 55444

(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
01620	Continued From page 12 assessment for all other assessments during the year and was not aware of the Uniform Assessment Tool requirement for all assessments. The licensee's Comprehensive Nursing Assessment policy dated August 1, 2021, indicated the nursing reassessment would include all the elements of the uniform assessment tool as required. Minnesota Administrative Rule 4659.0140 dated August 11, 2021, indicated a nursing assessment or reassessment must include all required content of the uniform assessment tool. Minnesota Administrative Rule 4659.0150 dated August 11, 2021, indicated all required content of the uniform assessment tool. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		

DEPARTMENT OF HEALTH

Type: Full
Date: *07/30/24*
Time: 14:18:38
Report: 1036241140

Food and Beverage Establishment Inspection Report

Location:
Sabainah Healthcare Inc
1816 Yellowstone Trail
Brooklyn Park, MN55444
Hennepin County, 27

Establishment Info:
ID #: 0037632
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632214214
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

OBSERVED EGGS STORED OVER RTE FOOD IN THE KITCHEN FRIDGE. ISSUE CORRECTED ON SITE.

Corrected on Site

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

OBSERVED AN OPENED CONTAINER OF CREAM CHEESE IN THE FRIDGE WITH NO DATE MARKING. ISSUE CORRECTED ON SITE.

Corrected on Site

7-100 Toxic Labeling

7-102.11 ***** Priority 2 *****

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

OBSERVED AN UNLABELED SPRAY BOTTLE SOLUTION UNDER THE SINK. PER STAFF, THE SOLUTION WAS BLEACH/WATER MIXTURE. ISSUE CORRECTED ON SITE.

Corrected on Site

Food and Beverage Establishment Inspection Report

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CFPM EMPLOYED AT ESTABLISHMENT. INSTRUCTIONS FOR APPLICATION PROVIDED TO ESTABLISHMENT.

Comply By: 08/20/24

Surface and Equipment Sanitizers

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SANTIZER SPRAY BOTTLE
Violation Issued: No

UTENSIL SURFACE TEMP: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/CREAM CHEESE
Temperature: 39 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

Process/Item: Ambient Temp
Temperature: -1 Degrees Fahrenheit - Location: FREEZER
Violation Issued: No

Process/Item: Ambient Temp
Temperature: 0 Degrees Fahrenheit - Location: BASEMENT FREEZER
Violation Issued: No

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

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. SURVEYOR FROM HRD WAS CARL SAMROCK. INSPECTION CONDUCTED IN PRESENCE OF JOHN IBE, THE PERSON IN CHARGE. AT TIME OF INSPECTION, ESTABLISHMENT HAD TWO RESIDENTS. ALL VIOLATIONS WERE DISCUSSED WITH THE PERSON IN CHARGE DURING INSPECTION.

THIS FACILITY DOES NOT HAVE COMMERCIAL GRADE ANSI EQUIPMENT. ALL FOOD MUST BE SERVED THE SAME DAY IT IS PREPARED, AND LEFTOVERS CAN NEVER BE SAVED.

DISCUSSED ALL ORDERS ON SITE IN ADDITION TO THE FOLLOWING WITH JOHN AND JANET IBE:
- EMPLOYEE ILLNESS LOG AND EXCLUSION POLICY.
- HAND WASHING POLICY AND REVIEW.
- PROPER FOOD STORAGE.
- GLOVE USAGE.
- THERMOMETER USE AND CALIBRATION.
- SANITIZER USE AND TEST KITS.

- DATE MARKING.
- PEST CONTROL.
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS.
- ANSI 184 STANDARD FOR RESIDENTIAL DISH WASHER.

FOR CORRECT BY DATES REFER TO COMPLETE REPORT ISSUED BY HRD.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1036241140 of 07/30/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
JOHN IBE
PERSON IN CHARGE

Signed:_____
Jeff Johanson