Electronically Delivered

February 19, 2025

Licensee
Calvary Assisted Living LLC
11485 Terrace Road Northeast
Blaine, MN 55434

RE: Project Number(s) SL40795015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on January 17, 2025, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The Department of Health 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. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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

Per 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 residents/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 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 Department of Health 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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 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
	40795	A. BUILDING: _____ B. WING _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVARY ASSISTED LIVING LLC	11485 TERRACE ROAD NE BLAINE, MN 55434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40795015-0 On January 13, 2025, through January 15, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were three resident(s); three receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	

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0 480	Continued From page 1	0 480		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	0 480		

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0 480	Continued From page 2 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated January 13, 2025 for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement an individual abuse prevention plan (IAPP) to contain all the required information for one of three residents (R1). 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).	0 630		

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0 630	Continued From page 4 The findings include: On January 14, 2025, at 9:20 a.m., the surveyor observed owner (O)-C administer medications to R1. R1 was admitted to the licensee on July 3, 2024, with diagnoses including type 2 diabetes mellitus, bipolar disorder, major depressive disorder, and chronic kidney disease. R1's Service Plan dated August 2, 2024, indicated R1 received services including medication administration, assistance with dressing, bathing, laundry, housekeeping, and safety checks. R1's resident record included an IAPP which contained: - an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; - the person's risk abusing other vulnerable adults. R1's record included an IAPP which lacked: - statements of specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults, abuse includes self-abuse. On January 14, 2025, at 3:00 p.m., licensed assisted living director (LALD)-A and owner O-C verified R1's IAPP lacked all the requirements. On January 15, 2025, at 11:05 a.m., clinical nurse supervisor (CNS)-B stated the prior nurse completed the IAPP for R1 and had reviewed it but did not realize it was missing the interventions to minimize the risk for abuse.	0 630		

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0 630	Continued From page 5 The licensee's 6.05 Individual Abuse Prevent Plan policy, dated July 6, 2024, indicated the licensee will develop and implement an individual abuse prevention plan for each vulnerable adult. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: - other vulnerable adults; - the person's risk of abusing other vulnerable adults: and - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults, abuse includes self-abuse. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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.	0 680		

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0 680	Continued From page 6 (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 develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, employees, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: On January 13, 2025, at 1:00 p.m., licensed assisted living director (LALD)-A provided the evaluator with a binder that contained the emergency preparedness manual and indicated the contents were the licensee's EPP. The licensee's emergency preparedness plan (EPP), dated July 1, 2024, lacked the required content: - missing resident quarterly review;	0 680		

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0 680	Continued From page 7 - description of the population served by licensee; - a process for EPP collaboration with regional, state and Federal EPP officials/organizations; - the development of policies/procedures to address: - sheltering in place for residents, staff, and volunteers who remain in the facility; and - use of volunteers; and - roles under a waiver declared by Secretary. - exercises to test the EPP at least twice per year, including unannounced drills using the EPP. On January 15, 2025, at 10:45 a.m., LALD-A and owner (O)-C both agreed their emergency preparedness plan was missing some of the required content, they did not have evidence of any drills, or have the missing person policy reviewed quarterly. The licensee's 9.01 Emergency Preparedness Plan policy dated July 1, 2024, indicated the licensee's emergency preparedness plan will include all required elements of appendix Z. The licensee will conduct, at minimum, two emergency preparedness drills every 12 months - these drills to not include required fire/evacuation drills. The licensee's 2.28 Missing Resident policy dated July 1, 2024, indicated the licensee will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subp. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan.	0 680		

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0 680	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide approved electrical extension cords in compliance with Minnesota Fire Code	0 780		

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0 780	Continued From page 9 under Minnesota Rules chapter 7511. These deficient conditions had the ability to affect all 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, 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: On January 15, 2025, at approximately 9:00 a.m. the surveyor toured the facility with owner (O)-C. During the tour, the surveyor observed use of unapproved/unlisted extension cords being used in bedrooms 3 and 4. During the facility tour interview on January 15, 2025, O-C verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 10 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 810		

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0 810	Continued From page 11 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 January 15, 2025, at approximately 10:00 a.m. owner (O)-C provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and	0 810		

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0 810	Continued From page 12 evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On January 15, 2025, O-C stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. O-C lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On January 15, 2025, O-C stated they understood the requirements for training residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01440 SS=F	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	01440		

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01440	Continued From page 13 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 an appropriate licensed health professional, or a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 calendar days after the date on which the individual began working for the facility and first performed the delegated task for three of three direct care employees (licensed assisted living director (LALD)-A), owner (O)-C, and 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 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: On January 14, 2025, at 9:20 a.m., the surveyor observed LALD-A prepare breakfast for all	01440		

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01440	Continued From page 14 residents of the facility and O-C administer medications to R1. LALD-A and O-C were hired on July 1, 2024, to provide supervision of staff and direct care services to residents of the assisted living facility. ULP-D was hired on September 26, 2024, to provide direct care services to the residents of the assisted living facility. LALD-A, O-C, and ULP-D's employee records all lacked documentation of direct supervision of staff performing delegated tasks within 30 calendar days after the date on which the individual begins working for the facility and first performs delegated tasks. On January 15, 2025, at 10:35 a.m., LALD-A stated the 30-day supervision was not completed by the nurse because they were unaware a 30-day supervision was required. On January 15, 2025, at 11:35 a.m., the clinical nurse supervisor (CNS)-B stated she was not aware that a 30-day supervision need to be completed. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated July 6, 2024, indicated 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 licensee and first performs the delegated tasks for the residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01440		

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01440	Continued From page 15 (21) days	01440		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83.	01460		

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01460	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for one of two employees (clinical nurse supervisor (CNS)-B). 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: During the entrance conference on January 13, 2025, at 10:00 a.m., licensed assisted living director (LALD)-A stated they were aware of the required contents for the employee records. CNS-B stated she was the facility nurse and completes the assessments on the residents. CNS-B was hired on July 18, 2024, to provide supervision and oversite to unlicensed personnel and to provide direct services to residents. CNS-B's employee record lacked documentation to indicate CNS-B completed orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. On January 14, 2025, at 3:40 p.m., LALD-A and owner (O)-C stated they did not have any evidence that orientation training had been	01460		

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01460	Continued From page 17 completed by CNS-B because they thought that since she trained the unlicensed staff on this same information, they did not need evidence she had completed the training in her record. On January 15, 2025, at 11:00 a.m., CNS-B stated she did complete some orientation training, but it was not documented. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated July 6, 2024, indicated orientation must be completed once for each staff person and is not transferable to another home care provider. All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified. Evidence of the completion of required orientation topics must be kept in the employee record of each staff person having completed the orientation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed	01530		

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01530	Continued From page 18 at least eight hours of initial training on topics specified under paragraph (b) within 160 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 interview, and record review, the licensee failed to ensure supervisors of direct-care staff received at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date for one of two employees (clinical nurse supervisor (CNS)-B). 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: CNS-B was hired on July 13, 2024, to provide	01530		

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01530	Continued From page 19 supervision and oversite to unlicensed personnel and to provide direct services to residents. CNS-B's employee record lacked evidence of any dementia training that was completed within 120 working hours of CNS-B's employment start date under the assisted living license. On January 14, 2025, at 3:40 p.m., licensed assisted living director (LALD)-A and owner (O)-C stated they did not have any evidence that CNS-B had completed any dementia care training because they thought that since she trained the unlicensed staff on this same information, they did not need evidence she had completed the training in her record. On January 15, 2025, at 11:00 a.m., CNS-B stated she did complete some dementia care training, but it was not documented anywhere. The licensee's 5.03 Dementia Training policy dated July 1, 2024, indicated supervisors of direct-care staff will complete 8 hours of initial training within 120 working hours of employment start date. Required dementia training topics include: -An explanation of Alzheimer's disease and other dementias; -Assistance with activities of daily living; -Problem solving with challenging behaviors; -Communication skills; and -Person centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

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01620	Continued From page 20	01620		
01620 SS=D	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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment not to exceed 90 calendar days from the last date of assessment for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620		

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01620	Continued From page 21 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: R1 was admitted to the licensee on July 3, 2024, with diagnoses including type 2 diabetes mellitus, bipolar disorder, major depressive disorder, and chronic kidney disease. R1's Service Plan dated August 2, 2024, indicated R1 received services including medication administration, assistance with dressing, bathing, laundry, housekeeping, and safety checks. R1's record included an initial assessment dated July 3, 2024, and a 14-day assessment dated July 14, 2024. The following 90- day assessment's for R1 were completed late: - October 3, 2024, late by 2 days; and - January 1, 2025, late by 12 days, On January 14, 2025, at 3:00 p.m., licensed assisted living director (LALD)-A and owner (O)-C stated they agreed the first 90-day assessment for R1 was late and the 90-day assessment due on January 1, 2025, had not yet been completed by the nurse because they just realized it was due. On January 15, 2025, at 11:10 a.m., clinical nurse supervisor (CNS)-A stated the reason R1's 90-day assessment was late was because she was	01620		

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01620	Continued From page 22 unable to come in the day it was due because of an illness. CNS-B stated R1's 90-day assessment due January 1, 2025, was missed due to a communication error and switching to a new electronic charting system. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated July 1, 2024, indicated 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. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record,	01640		

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01640	Continued From page 23 including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written service plan was implemented no later than 14 days after the date services were first provided for two of three residents (R1 and R2). Additionally, the licensee failed to ensure the current service plan included a signature or other authentication by the resident and the licensee to document agreement on the services to be provided for one of three residents (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 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 January 14, 2025, from 9:00 a.m. through 9:45 a.m., the surveyor observed owner (O)-C administer medications to R1 and R2. R1 R1 was admitted to the licensee on July 3, 2024, with diagnoses including type 2 diabetes mellitus, bipolar disorder, major depressive disorder, and chronic kidney disease.	01640		

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01640	Continued From page 24 R1's medical record included a Service Plan signed August 2, 2024 (30 days after start of services), the service plan indicated R1 received services including medication administration, assistance with dressing, bathing, laundry, housekeeping, and safety checks. R2's record lacked a signed written service plan within 14 days of R2's start of services. R2 R2 was admitted to the licensee on August 23, 2024, with diagnoses including bipolar disorder, anxiety, and sleep disorder. R2's medical record included a Service Plan, signed by the nurse only, dated September 13, 2024 (21 days after start of services), that indicated R2 received services including medication administration, assistance with dressing, bathing, laundry, housekeeping, and safety checks. R2's record lacked a signed written service plan within 14 days of R2's start of services. In addition, R2's medical record also lacked a service plan which included a signature or other authentication by the resident. On January 14, 2025, at 11:35 a.m., licensed assisted living director (LALD)-A and owner (O)-C both stated both service plans for R1 and R2 were not completed within 14 days of services starting because they thought the requirement was within 30 days. LALD-A and O-C also both stated R2's service plan was missing the resident signature and the nurse must have not realized it needed to be signed by the resident.	01640		

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01640	Continued From page 25 On January 15, 2025, at 11:10 a.m., clinical nurse supervisor (CNS)-B stated she missed having the resident sign the service plan because the signature lines on the form did not print out correctly. The licensee's 6.08 Service Plan policy dated July 1, 2024, indicated within 14 days after the date that services are first provided to a resident, licensee will finalize a written Service plan. The Service plan and any revision shall include a signature or other authentication by licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;	01730		

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01730	Continued From page 26 (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with all required content for one of three residents (R1). 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	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40795	A. BUILDING: _____ B. WING _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVARY ASSISTED LIVING LLC	11485 TERRACE ROAD NE BLAINE, MN 55434

(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
01730	Continued From page 27 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted to the licensee on July 3, 2024, with diagnoses including type 2 diabetes mellitus, bipolar disorder, major depressive disorder, and chronic kidney disease. R1's Service Plan dated August 2, 2024, indicated R1 received services including medication administration, assistance with dressing, bathing, laundry, housekeeping, and safety checks. R1's Individualized Medication Management Plan dated July 3, 2024, lacked the following required information: -a statement describing the medication management services that will be provided; and -identification of medication management tasks that may be delegated to unlicensed personnel. On January 14, 2025, at 10:15 a.m., licensed assisted living director (LALD)-A and owner (O)-C both stated they agreed the medication management plan for R1 was missing some of the required information and it must have been when the previous nurse filled the paperwork out. On January 15, 2025, at 11:20 a.m., clinical nurse supervisor (CNS)-B stated the previous nurse completed the medication assessment with R1 and she had reviewed it but did not realize it was missing some of the required elements. The licensee's 7.03 Medication Management Individualized Plan policy dated July 1, 2024	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40795	A. BUILDING: _____ B. WING _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVARY ASSISTED LIVING LLC	11485 TERRACE ROAD NE BLAINE, MN 55434

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01730	Continued From page 28 indicated the licensee will develop and maintain a current individualized medication management record for each resident based on the residence assessment that must contain the following: - a statement describing the medication management services that will be provided; and - identification of medication management tasks that may be delegated to unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01850 SS=D	144G.71 Subd. 16 Written or electronic prescription When a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed in the resident's record. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure written or electronically recorded prescriptions were communicated to the registered nurse (RN) for one of two residents (R1). 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).	01850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40795	A. BUILDING: _____ B. WING _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVARY ASSISTED LIVING LLC	11485 TERRACE ROAD NE BLAINE, MN 55434

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01850	Continued From page 29 The findings include: R1 was admitted to the licensee on July 3, 2024, with diagnoses including type 2 diabetes mellitus, bipolar disorder, major depressive disorder, and chronic kidney disease. R1's Service Plan dated August 2, 2024, indicated R1 received services including medication administration, assistance with dressing, bathing, laundry, housekeeping, and safety checks R1's record contained an electronic prescription for hydroxyzine HCL 10mg tablet (a medication for anxiety). Take one tablet by mouth once daily as needed. R1's medication administration record(MAR) for December 2024 and January 2025 lacked the hydroxyzine order. R1's PRN (as needed) medication notes form dated December 2024, indicated R1 had been given the hydroxyzine eight times for anxiety. On January 14, 2025, at 10:45 a.m., the surveyor observed the locked medication cabinet with owner (O)-C. The surveyor observed R1's medications which included a punch pack that contained hydroxyzine 10 milligram (mg) tablets. On January 14, 2025, at 11:00 a.m., O-C stated he is not sure why the medication is not on R1's MAR but he does not take this medication often and the pharmacy must have not added it to the MAR through the pharmacy connect. O-C stated clinical nurse supervisor (CNS)-B reviews all the orders for medications and should put them in the MAR if pharmacy connect does not add it.	01850		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	40795	A. BUILDING: _____ B. WING _____	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALVARY ASSISTED LIVING LLC	11485 TERRACE ROAD NE BLAINE, MN 55434

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01850	Continued From page 30 On January 15, 2025, at 11:30 a.m., CNS-B stated she thought the hydroxyzine was on the MAR and must have missed adding it onto the MAR. The licensee's Medication and Treatment Administration and Delegation policy dated July 6, 2024, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, the licensee will ensure the registered nurse has: - specified, in writing, specific instructions for each resident and documented those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01850		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *01/13/25*
Time: 13:22:37
Report: 1029251006

Food and Beverage Establishment Inspection Report

Location:

CALVARY ASSISTED LIVING LLC
11485 TERRACE ROAD NE
Blaine, MN55434
Anoka County, 02

Establishment Info:

ID #: 0043951
Risk:
Announced Inspection: Yes

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
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.

SHELL EGGS AND BEEF CHUBS NOT SAFELY SEPARATED FROM READY TO EAT FOODS. CORRECTED DURING INSPECTION. PROTECTION FROM CONTAMINATION DISCUSSED.

Comply By: 01/13/25

3-500C Microbial Control: date marking

3-501.17A ***** Priority 2 *****

MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared 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.

OPENED DELI MEATS NOT DATE MARKED. CORRECTED DURING THE DURING THE INSPECTION.

Comply By: 01/13/25

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

SEVERAL TCS ITEMS HELD BEYOND SAME DAY SERVICE. CORRECTED DURING INSPECTION. SAME DAY SERVICE DISCUSSED.

Comply By: 01/13/25

Food and Equipment Temperatures

Process/Item: COLD HOLD/MILK
Temperature: 40 Degrees Fahrenheit - Location: COOLER INTERIOR
Violation Issued: No

Process/Item: COLD HOLD/BUTTER
Temperature: 41 Degrees Fahrenheit - Location: COOLER DOOR
Violation Issued: No

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

Topics covered:
- Employee illness logging and exclusion policy
- Foodborne illness reporting requirements
- Common contagious foodborne illness pathogens
- Vomit/fecal matter cleanup protocol
- Temperature control
- Protection from contamination
- Highly susceptible population
- Sanitizing
- Employee hygiene and handwashing
- Barehand contact and glove/utensil use

Establishment uses GE (MOD GDT550PYR7FS) to sanitize equipment and utensils.

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 1029251006 of 01/13/25.

Certified Food Protection Manager: ABDI D. WODAJO

Certification Number: 124045 Expires: 05/10/27

Inspection report reviewed with person in charge and emailed.

Signed: _____
ABDI WODAJO
OWNER - CFPM

Signed: Trevor McCliment
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029251006

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	2	Date	01/13/25
No. of Repeat RF/PHI Categories Out	0	Time In	13:22:37
Legal Authority MN Rules Chapter 4626		Time Out	

CALVARY ASSISTED LIVING LLC	**Address** 11485 TERRACE ROAD NE	**City/State** Blaine, MN	**Zip Code** 55434	**Telephone**
License/Permit # 0043951	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

		Safe Food and Water	COS	R
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

		Proper Use of Utensils	COS	R
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 01/14/25

Inspector (Signature) *Trevor McCliment*