DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 27, 2025

Licensee
Warroad Senior Living Center
1401 Lake Street Northwest
Warroad, MN 56763

RE: Project Number(s) SL30793016

Dear Licensee:

On October 22, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 7, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

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Electronically Delivered

September 22, 2025

Licensee
Warroad Senior Living Center
1401 Lake Street Northwest
Warroad, MN 56763

RE: Project Number(s) SL30793016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 7, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. 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 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

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 Department of Health 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.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30793	A. BUILDING: _____ B. WING _____	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARROAD SENIOR LIVING CENTER	1401 LAKE STREET NW WARROAD, MN 56763

(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: SL30793016-0 On August 4, 2025, through August 7, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 43 residents; 43 receiving services under the Assisted Living Facility license. An immediate correction order was identified on August 7, 2025, issued for SL30793016-0, tag identification 1290. The licensee took action on August 7, 2025, to mitigate the risk; however, the scope and level remains at level 3/Widespread (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (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; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 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 August 5, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
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 observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. In addition, the licensee failed to ensure the missing	0 680		

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0 680	Continued From page 4 resident plan was reviewed quarterly. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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: During the entrance conference on August 4, 2025, at 1:15 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was familiar with the current minimum assisted living requirements. The licensee's EPP dated November 4, 2024, lacked the following required content: - development of a policy/procedure to address the facility's role in providing care and treatment at alternative sites under a 1135 waiver; and - a quarterly review of the missing resident policy. On August 6, 2025, at 12:25 p.m., LALD/RN-A stated the licensee had reviewed the missing resident policy twice per year, however, LALD/RN-A was not aware the missing resident policy was required to be reviewed on a quarterly basis. LALD/RN-A further stated the licensee's EPP did not include information regarding the licensee's role in providing care and treatments at alternative sites under a 1135 waiver. The licensee's EDP-01-001 Emergency and	0 680		

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0 680	Continued From page 5 Disaster Plan policy dated November 4, 2024, indicated a written emergency and disaster plan is established to meet staff and residents' health, safety, and security needs during emergencies or disasters. The licensee's 01-306 Missing Resident Policy dated May 28, 2022, did not address how often the policy was reviewed. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 6 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. 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, 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 a facility tour on August 5, 2025, from 1:30 p.m. to 3:00 p.m., with director of maintenance (DM)-H, and licensed assisted living director/registered nurse (LALD/RN)-A, the following observations were made of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: SPECIAL EXIT DOOR LOCKING There was controlled exit door hardware requiring a code to exit installed in the D wing at the exit door leading into the stairway on the west and the exit door leading to the common shared space from the open stairway area of the D wing.	0 775		

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0 775	Continued From page 7 There was not an emergency release switch installed at the nurse station or other approved location designed to release all controlled exit doors for exiting in the event of an emergency. The was not operating procedures for operation of the controlled exit locking system provided in writing in the Fire Safety and Evacuation Plan (FSEP) employee procedures. FIRE-RESISTANT RATED WALL MAINTENANCE There was a six-inch-by-six-inch hole through the inside membrane of the fire-resistant rated wall inside the mechanical closet near the exterior door leading to the exterior fenced activity area. It was explained that fire-resistant rated wall membranes are required to be maintained as designed and installed at the time of construction approval. FIRE-RESISTANT RATED DOORS The fire-resistant rated door leading out of the commercial kitchen hallway to the exit corridor and the door leading into the nurse storage room from the exit corridor were held open with devices not designed to automatically release the door to close and latch upon the detection of smoke. These two doors were located in the two-hour fire-resistant rated wall separating the assisted living from other occupancies. It was explained that all fire-resistant rated doors are required to automatically close and latch. During the facility tour DM-H, and LALD/RN-A, verified the above listed observations while	0 775		

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0 775	Continued From page 8 accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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.	0 810		

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0 810	Continued From page 9 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 required content. 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, 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 August 5, 2025, at 12:30 p.m., licensed assisted living director/registered nurse (LALD/RN)-A, 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 provided FSEP updated November 4, 2024, failed to include the following: The available FSEP included standard resident evacuation procedures, but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs	0 810		

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0 810	Continued From page 10 of residents. The FSEP failed to include evacuation status and unique needs for evacuation for each individual resident in writing and available for immediate reference in the event of a fire or similar emergency. The individual resident unique needs for evacuation are required to be readily available to all staff, at all times within the facility, for use in responding to a fire or similar emergency. During an interview on August 5, 2025, at 12:30 p.m., LALD/RN-A, stated the evacuation status/ unique needs for evacuation for each resident was not available in writing for immediate reference by staff. TIME PERIOD FOR CORRECTION: Seven (7) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	01290		

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	30793	A. BUILDING: _____ B. WING _____	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARROAD SENIOR LIVING CENTER	1401 LAKE STREET NW WARROAD, MN 56763

(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
01290	Continued From page 11 This MN Requirement is not met as evidenced by: *Amended on August 25, 2025, to include background study affiliation. Based on interview and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for one of nine employees (housekeeping (HSKPG)-E). In addition, the licensee failed to affiliate a background study to the licensee's healthcare facility identification number (HFID) for one of eight employees (dietary aide (DA)-K). This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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: This resulted in an immediate correction order on August 6, 2025. During the entrance conference on August 4, 2025, at 1:30 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was aware of required contents in an employee record. HSKPG-E was hired on January 25, 2016, and	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30793	A. BUILDING: _____ B. WING _____	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARROAD SENIOR LIVING CENTER	1401 LAKE STREET NW WARROAD, MN 56763

(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
01290	Continued From page 12 had begun to provide cleaning in the assisted living effective August 1, 2021. The monthly schedules dated July 2025, and August 2025, respectively indicated HSKPG-E was scheduled to work four out of 37 opportunities. HSKPG-E's employee record lacked a current cleared background study. On August 6, 2025, at 10:00 a.m., LALD/RN-A stated the human resource department was responsible for completed background studies on all employees. On August 6, 2025, at 10:09 a.m., through 10:17 a.m., the surveyor reviewed the NETStudy 2.0 website and rosters with LALD/RN-A and human resources (HR)-J. HR-J searched HSKPG-E's name on the NETStudy 2.0 website and the search results indicated no working individuals found. HR-J stated background studies were entered on the NETStudy 2.0 website upon hire with the licensee. LALD/RN-A stated HSKPG-E was a current employee of the licensee and worked unsupervised. On August 6, 2025, at 11:02 a.m., LALD/RN-A stated the HR department would not be notified of an employee's background study becoming ineligible if the employee did not have a background study in NETStudy 2.0. BACKGROUND STUDY AFFILIATION DA-K was hired on October 24, 2018, and had begun to provide meal assistance to residents at the assisted living facility effective August 1, 2021.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30793	A. BUILDING: _____ B. WING _____	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
01290	Continued From page 13 DA-K had a cleared background study dated October 10, 2018, affiliated with the HFID 26877. On August 6, 2025, at 10:09 a.m., HR-J stated DA-K was a current employee for the licensee and the previous human resource employee did not affiliate any dietary staff to the assisted living HFID. HR-J further stated all DA background studies were completed under the skilled nursing facility HFID 26877, and the DA background studies should have been affiliated with the assisted living HFID 30793, as well, since the dietary aides worked at both locations. The licensee's 02-002: Personnel Records policy dated May 24, 2022, indicated personnel records would include documentation of a completed criminal background study. Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible of until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30793	A. BUILDING: _____ B. WING _____	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01290	Continued From page 14 supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01550 SS=F	144G.64 (a) (4) Training in Dementia, Mental Illness, and De- (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two employees (director of maintenance (DM)-H, housekeeping (HSKPG)-E) received the required amount of mental illness and de-escalation in the required time frame. In addition, the licensee failed to ensure one of two employees (DM-H) received annual dementia training for each 12	01550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30793	A. BUILDING: _____ B. WING _____	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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
01550	Continued From page 15 months of employment after hire. 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: During the entrance conference on August 4, 2025, at 1:30 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was aware of required contents in an employee record. DM-H DM-H was hired on October 5, 2023, to provide maintenance around the assisted living facility. On August 5, 2025, from 1:30 p.m. through 3:00 p.m., the surveyor observed DM-H provide a facility tour with the Minnesota Department of Health engineer surveyor. DM-H's online transcript indicated DM-H had not completed any dementia training since October 4, 2023. HSKPG-E HSKPG-E was hired on January 25, 2016, and had begun to provide cleaning in the assisted living effective August 1, 2021. DM-H and HSKPG-E's employee records lacked two hours of initial training on mental illness and	01550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30793	A. BUILDING: _____ B. WING _____	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01550	Continued From page 16 de-escalation. In addition, DM-H's employee record lacked two hours of annual dementia training for each 12 months of employment. On August 5, 2025, at 3:43 p.m., LALD/RN-A stated HSKPG-E and DM-H were employees of the assisted living and worked at the attached nursing home. LALD/RN-A further stated HSKPG-E and DM-H were assigned nursing home regulation trainings and were not assigned the additional assisted living regulation trainings. LALD/RN-A stated LALD/RN-A was aware of the required mental illness and de-escalation trainings effective July 1, 2025, as direct care staff had completed the training. LALD/RN-A further stated DM-H should have completed two hours of annual dementia care training for the year of 2024, however, DM-H was not assigned to the online annual dementia trainings by the previous director. The licensee's 02-303 Annual Training policy dated March 25, 2024, indicated all assisted living employees will complete annual education including effective approaches for problem solving when working with challenging behaviors and effective approaches for communication with residents with dementia, Alzheimer's disease or related disorders. The policy did not address training on mental illness or de-escalation. The licensee's 02-302b: Assisted Living Dementia Training policy dated May 14, 2025, indicated non-direct care employees will have a minimum of two hours training on topics related to dementia for each 12 months of employment. No further information was provided.	01550		

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01550	Continued From page 17 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01550		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R4) with a consumer bed rail. 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: During the entrance conference on August 4, 2025, at 1:15 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee was familiar with the current minimum assisted living requirements.	02310		

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02310	Continued From page 18 R4's diagnoses included diabetes, congestive heart failure (CHF), and anxiety. R4's Service Agreement (service plan) dated January 18, 2025, indicated R4's services included medication administration, medication set up, TEDS (compression stockings), bathing, and housekeeping. R4's Bed Mobility Assistive Device Assessment dated March 28, 2025, indicated R4 had a portable bed rail installed on R4's bed and R4 used the portable bed rail for assistance getting in and out of bed. The portable bed rail was evaluated for safety and use at least every 90 days, R4 had an assessment on the portable bed rail, R4 understood the risks associated with the use of the portable bed rail, and the portable bed rail was installed properly per manufacturer's instructions. R4's Master Assessment dated June 20, 2025, indicated R4 had a portable bed rail and R4 was assessed for use of the portable bed rail. On August 5, 2025, at 7:06 a.m., the surveyor observed unlicensed personnel (ULP)-G administer R4's scheduled morning medication. R4's record lacked evidence the licensee referred to the Consumer Product Safety Commission (CPSC) website for bed rail recall information at least every 90 days with the bed rail assessment. On August 5, 2025, at 3:53 p.m., LALD/RN-A stated the licensee completed bed rail assessments for resident's at least every 90 days, however, the licensee only checked the CPSC website every six months for recalls on	02310		

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02310	Continued From page 19 portable bed rails. LALD/RN-A further stated the licensee did not document the dates the CPSC website was checked for recalls on portable bed rails. The licensee's 03-016 Side Rail Safety Assessment dated April 4, 2024, indicated the clinical nurse supervisor (CNS) will review the use of the bed rail during the monitoring and reassessment visits every 90 days. The bed rail assessment included to determine if the resident's side rail (bed rail) met or did not meet the FDA (Food and Drug Administration) or most current safety guidelines. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated July 1, 2025, Documentation about a resident's consumer bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences;	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 20 - Installation and sue according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Bemidji District Office
Minnesota Department of Health
706 5th St NW, Suite A
Bemidji, MN 56601
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

WARROAD SENIOR LIVING CENTER
1401 LAKE STREET NW
Warroad, MN 56763
Roseau County
Parcel:

Phone:

License Info

License: HFID 30793

Risk:
License:
Expires on:
CFPM: Shaelyn Simonson
CFPM #: FM120193; Exp: 11/20/2026

Inspection Info

Report Number: F1002251039
Inspection Type: Full - Joint
Date: 8/5/2025 Time: 11:00:00 AM
Duration: minutes
Announced Inspection: Yes
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 1
Delivery: Emailed

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: AT TIME OF INSPECTION, THERE WERE CONTAINERS OF COLD TCS FOOD (LETTUCE, CHEESE, ETC.) BEING STORED ON ICE AT THE COOK LINE IN THE MAIN KITCHEN AS WELL AS IN THE SERVING KITCHEN. THERE WERE ALSO TCS BEVERAGE ITEMS (MILK, JUICE, ETC.) BEING STORED ON ICE AT THE BEVERAGE STATION IN THE MAIN KITCHEN. STAFF INDICATED THE ITEMS ARE PLACED BACK INTO COOLERS FOLLOWING SERVICE. STAFF WERE INSTRUCTED TO DISCARD ALL OF THE COLD TCS FOOD THAT WAS BEING STORED ON ICE. IN THE FUTURE, COLD TCS FOODS MUST REMAIN UNDER MECHANICAL REFRIGERATION AT ALL TIMES UNLESS USING AN APPROVED TIME AS PUBLIC HEALTH CONTROL (TPHC) POLICY.
Comply By: 8/5/2025 Originally Issued On: 8/5/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.13B *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.
COMMENT: ESTABLISHMENT DOES NOT HAVE A METHOD AVAILABLE TO MEASURE THE UTENSIL SURFACE TEMPERATURE OF THE HOT WATER DISH MACHINES (3). PROVIDE THERMOLABELS OR DISH MACHINE THERMOMETER THAT HAS A MIN/MAX FUNCTION.
Comply By: 8/12/2025 Originally Issued On: 8/5/2025

New Order: 4-600 Cleaning Equipment and Utensils
4-602.11E *Priority Level: Priority 3 CFP#: 16*
MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.
COMMENT: A LIGHT COLORED SUBSTANCE WAS REMOVED FROM THE BAFFLE OF THE ICE MACHINE IN THE MAIN KITCHEN AT TIME OF INSPECTION. CLEAN AND SANITIZE THE ICE BIN ACCORDING TO MANUFACTURER'S INSTRUCTIONS AND AS OFTEN AS NEEDED TO PRECLUDE ACCUMULATION.
Comply By: 8/12/2025 Originally Issued On: 8/5/2025

Food & Beverage General Comment

This establishment is a facility that provides skilled nursing care, assisted living, supported living and

independent living. There is one main kitchen where all food is prepared and then it is subsequently delivered to designated serving areas. There is a domestic kitchen on site that was designed to be used as a serving area but is now only used as a snack kitchen. The dish machine in the snack kitchen is not in use. Staff was instructed to contact MDH prior to utilizing this dish machine to verify that it is functioning properly. There is also a bar that serves weekly happy hours and an area with hand dipped ice cream that is used sporadically.

Discussion:
Handwashing
Employee illness
Safe cleaning & sanitizing
Serving highly susceptible populations
Thermometer calibration - demonstration provided at time of inspection
CFPM duties
Time as Public Health Control (TPHC)

Note:
Staff indicated that any leftover food is not saved for later use. This establishment is allowed to conduct cooling but it must be done according to code requirements. Contact your inspector to discuss the cooling process if cooling takes place in the future.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Bemidji District Office inspection report number F1002251039 from 8/5/2025

Cassandra Hua

Shaelyn Simonson
Interim Kitchen Manager

Cassandra Hua, REHS
Public Health Sanitarian 3
218-308-2142
cassandra.hua@state.mn.us

Bemidji District Office
Minnesota Department of Health
706 5th St NW, Suite A
Bemidji, MN 56601

Temperature Observations/Recordings

Establishment Info

WARROAD SENIOR LIVING CENTER
Warroad
County/Group: Roseau County

Inspection Info

Report Number: F1002251039
Inspection Type: Full
Date: 8/5/2025
Time: 11:00:00 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: ON ICE AT BEVERAGE STATION at 47 Degrees F.
Comment: MAIN KITCHEN
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: LETTUCE, CHEESE, ETC.**; Temperature Process:** Cold-Holding
Location: ON ICE AT COOK LINE at 43 Degrees F.
Comment: MAIN KITCHEN & SERVING KITCHEN
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: TOMATOES**; Temperature Process:** Cold-Holding
Location: TRUE PREP COOLER at 34 Degrees F.
Comment: MAIN KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: BUTTER **; Temperature Process:** Cold-Holding
Location: ARCTIC AIR COOLER at 41 Degrees F.
Comment: MAIN KITCHEN
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT TEMP**; Temperature Process:** Ambient Air
Location: METRO C5 WARMER at 170 Degrees F.
Comment: MAIN KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: HOT ITEMS ON STEAM TABLE **; Temperature Process:** Hot-Holding
Location: Steam Table at 170+ Degrees F.
Comment: MAIN KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Beverage Cooler at 39 Degrees F.
Comment: MAIN KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHICKEN SALAD**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT TEMP**; Temperature Process:** Ambient Air
Location: Walk-in Freezer at 0 Degrees F.
Comment: FROZEN SOLID
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** HALF & HALF**; Temperature Process:** Cold-Holding
Location: MAYTAG DOMESTIC REFRIGERATOR at 41 Degrees F.
Comment: SNACK KITCHEN
Violation Issued?: No

Equipment Temperature: **Product/Item/Unit:** AMBIENT TEMP**; Temperature Process:**
Location: E-LINE FREEZER at 0 Degrees F.
Comment: SERVING KITCHEN
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** HALF & HALF**; Temperature Process:** Cold-Holding
Location: BEV AIR COOLER at 39 Degrees F.
Comment: SERVING KITCHEN
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** BUTTER**; Temperature Process:** Cold-Holding
Location: FRIGIDAIRE COOLER at 40 Degrees F.
Comment: BIRCH BEACH KITCHENETTE
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MILK**; Temperature Process:** Cold-Holding
Location: FRIGIDAIRE COOLER at 40 Degrees F.
Comment: LOTW KITCHENETTE
Violation Issued?: No

Bemidji District Office
Minnesota Department of Health
706 5th St NW, Suite A
Bemidji, MN 56601

Sanitizer Observations/Recordings

Establishment Info

WARROAD SENIOR LIVING CENTER
Warroad
County/Group: Roseau County

Inspection Info

Report Number: F1002251039
Inspection Type: Full
Date: 8/5/2025
Time: 11:00:00 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Main Kitchen **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Birch Beach Kitchenette **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: LOTW Kitchenette **Equal To** 160 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: 3-Comp Sink **Equal To** 200 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1002251039

Food Establishment Inspection Report

Bemidji District Office
Minnesota Department of Health
706 5th St NW, Suite A
Bemidji, MN 56601

No. of Risk Factor/Intervention/Violations	0	Date: 8/5/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:00 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
WARROAD SENIOR LIVING CENTER	1401 LAKE STREET NW	Warroad, MN	56763	

License/Permit #:	Permit Holder:	Purpose of Inspection:	Est. Type:	Risk Category:
HFID 30793		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions 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" or OUT 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

			COS	R
		Safe Food and Water		
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		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 and plan review		

Person in Charge (signature)

Inspector (signature) Cassandra Hua

Follow-up: Follow-up Date: