DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

June 28, 2023

Licensee
Thrive Better
2518 Washington Street Northeast
Minneapolis, MN 55418

RE: Project Number(s) SL38677015

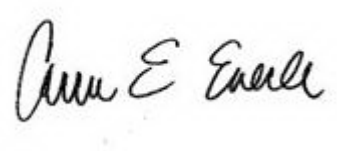
Dear Licensee:

On June 22, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 27, 2023, survey were corrected. 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,



Carrie Euerle, Supervisor
State Rapid Response Team
Email: carrie.euerle@state.mn.us
Telephone: 651-242-8846 Fax: 651-215-6894

JMD

Electronically Delivered

May 31, 2023

Licensee
Thrive Better
2518 Washington Street Northeast
Minneapolis, MN 55418

RE: Project Number(s) SL38677015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care.** 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 April 27, 2023, 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.

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 and enforcement actions 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.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

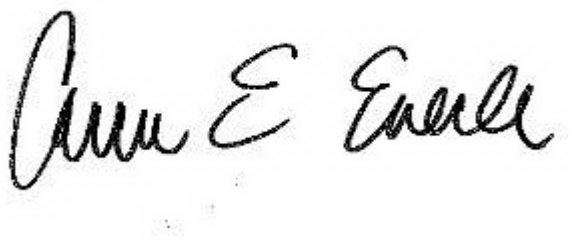
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

If you have any questions, please contact me.

Sincerely,



Carrie Euerle, Supervisor
State Rapid Response Team
Email: carrie.euerle@state.mn.us
Telephone: 651-242-8846 Fax: 651-215-6894

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38677	A. BUILDING: _____ B. WING _____	04/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THRIVE BETTER	2518 WASHINGTON STREET NE MINNEAPOLIS, MN 55418

(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: SL38677015 On April 24, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were no residents receiving services under the provider's Provisional Assisted Living license. The following correction orders are issued:	0 000	STATE ASSISTED LIVING PROVIDER POC TEXT 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.	

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0 000	Continued From page 1	0 000	THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated April 24, 2023, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the license failed to maintain a tuberculosis (TB) infection control program based on guidelines by the Center for Disease Control (CDC) and Minnesota Department of Health and ensure written evidence a tuberculosis infection control plan was in place. The facility also failed to provide documentation that one of two employees (registered nurse (RN)-A) received TB testing upon hire at the facility within the recommended guidelines. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660		

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0 660	Continued From page 3 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 the potential to affect a large portion or all the residents). The findings include: On April 24, 2023, the licensee's administrator (ADM)-A indicated they had knowledge of Assisted Living Facility laws and rules. Two employee files were reviewed on April 24, 2023. RN-A's employee file included a screening for TB dated February 15, 2022. The screening included, "Mantoux test completed and negative. See attached for results and information." No documentation was attached to this screening. The facility was asked to provide the missing information for RN-A's TB results and the facility produced a quantiferon test dated April 2023. When asked if the documentation was the same as the screening results mentioned in February 2022, ADM-A affirmed RN-A's first TB test was the quantiferon test in April 2023. ADM-A indicated the facility did not have written evidence of a TB infection control and prevention plan. No further information was provided. Time Period for Correction: Twenty-one (21) Days	0 660		

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0 730	Continued From page 4	0 730		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received	0 730		

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0 730	Continued From page 5 and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included all required content including a signed service plan and documentation of provided services for one of one 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). The findings include: On April 24, 2023, a representative of the Minnesota Department of Health entered the facility. When asked, the facility administrator (ADM)-A acknowledged awareness of comprehensive home care laws and rules. R1's record was reviewed and failed to include the following content: - a discharge summary -documentation that the resident has received and reviewed the Assisted Living Bill of Rights	0 730		

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0 730	Continued From page 6 - documentation of services provided as identified in the service plan -evidence staff had been oriented to the service plan -a signed service plan. ADM-A affirmed R1's record did not contain all required content. The facility "Service Plan" policy, dated June 12, 2022, includes the following: "4. The initial service plan and any revisions are signed by a representative from Thrive Better Assisted Living and the resident or resident's representative, indicating agreement with the services to be provided." No further information was provided. Time Period for Correction: Twenty-one (21) Days.	0 730		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings,	0 800		

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0 800	Continued From page 7 grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, 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). Findings include: On April 27, 2023, at approximately 2:00 p.m., survey staff toured the facility with the Assisted Living Director (LALD)-A. During the facility tour, survey staff observed the following items: In the lower-level bathroom, it was observed that the shower doors did not have bottom tracks and were loosely attached to the door jamb. In lower-level bedroom #5, it was observed that the egress window was obstructed by a plastic well cover that was installed lower than the window head. With further review, it was observed that the exterior siding trim was installed lower than the window head, and the trim obstructed the egress window from opening fully. It was observed that the ceiling light fixture in the hall outside of bedroom #5 was broken, and the light fixture cover was missing.	0 800		

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0 800	Continued From page 8 During the tour, LALD-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system	0 810		

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0 810	Continued From page 9 activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review, observation, and interview, the licensee failed to provide required employee training on fire safety and evacuation; failed to provide fire protection procedures necessary for residents and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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). Findings include: An interview and record review were conducted on April 27, 2023, at approximately 2:00 p.m. with the Licensed Assisted Living Director (LALD)-A on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of available documentation indicated that the fire safety and evacuation plan did not show the location and number of resident rooms. Record review of the available documentation indicated that the licensee did not have fire	0 810		

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0 810	Continued From page 10 protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview, LALD-A indicated the fire safety and evacuation plan lacked fire protection procedures for the resident. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. During the interview, LALD-A verified that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=H	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced	0 820		

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0 820	Continued From page 11 by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. This practice resulted in a level 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 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 April 27, 2023, at approximately 2:00 p.m., survey staff toured the facility with the License Assisted Living Director (LALD)-A. During the facility tour, it was observed that bedroom #1 and bedroom #2 on the upper level did not have windows that met the minimum size requirements for egress escape. The sleeping rooms were not occupied by residents. The clear openable area of the opened windows measured 16 inches in height and 25 1/2 inches in width and did not meet the minimum required opening for existing sleeping rooms of 648 square inches. This deficient condition was verified by LALD-A accompanying the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 820		

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul
651-201-5000

Type: Full
Date: *04/24/23*
Time: 10:30:00
Report: 1031231093

Food and Beverage Establishment Inspection Report

Location:
Thrive Better
2518 Washington Street NE
Minneapolis, MN55418
Hennepin County, 27

Establishment Info:
ID #: 0041193
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

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.

4-300 Equipment Numbers and Capacities
4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

ESTABLISHMENT DOES NOT HAVE A THIN PROBE THERMOMETER.

Comply By: 04/28/23

4-300 Equipment Numbers and Capacities
4-302.13B ***** Priority 2 *****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT MISSING IRREVERSIBLE MEASURING DEVICE. PROVIDE IRREVERSIBLE MEASURING DEVICE AND MEASURE UTENSIL TEMPERATURE (160F REQUIRED) AT REGULAR INTERVALS.

Comply By: 05/02/23

4-300 Equipment Numbers and Capacities
4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

ESTABLISHMENT DOES NOT HAVE SANITIER TESTING KIT ON SITE. PROVIDE AND USE TEST KIT TO CHECK SANITIZER CONCENTRATION.

Comply By: 04/28/23

6-300 Physical Facility Numbers and Capacities

6-301.12 ***** Priority 2 *****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

PAPER TOWELS MISSING FROM BOTH BATHROOMS. COMPLY WITH ABOVE RULE.

Comply By: 04/26/23

6-300 Physical Facility Numbers and Capacities

6-301.20

MN Rule 4626.1450 Provide a waste receptacle for individual towels at the handwashing sink where individual towels are used.

DOWNSTAIRS BATHROOM MISSING GARBAGE CAN. COMPLY WITH ABOVE RULE.

Comply By: 04/28/23

Surface and Equipment Sanitizers

Ambient Air Temp: = at 31 Degrees Fahrenheit
Location: Refrigerator (empty)
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	4	1

Inspection conducted by Chris F.

All violations discussed with Najma during the inspection.

NOTES:

- Establishment has a residential kitchen (4626.0506(G)(2)) Same-day service only. No saving and reheating of foods or preparation of foods the day prior to eating. Any remaining food from meals to be removed/discarded at end of day.

- Staff must prepare sanitizer bucket and store their wiping rag in it daily. Check concentration of sanitizer throughout day with test strips. Dump and replace sanitizer solution as needed.

- Make sure to datemark any prepared cold items that are kept in refrigerator.

- Gloves should be used for single-purpose only; switch gloves whenever leaving kitchen to do other work.

- Cutting boards should be utilized as food contact surfaces and not counters or plates.

- Establishment has NSF commercial dishwasher - can use dishwasher to wash, rinse, and sanitize (use sanitize setting on washer).

- - Establishment needs to check dish washer utensil temperature weekly (160F required). If utensil temp not reaching 160F, use washer to wash/rinse and sink basin with sanitizer solution to sanitize dishes then air

dry, as discussed during inspection.

- 2-Comp sink has left basin designated for handwashing and the right basin for product washing/prep sink.

- When preparing food, make sure to use a thin-probe thermometer to check temperatures.

- When preparing food from raw, make sure to use a thermometer to check temperatures.

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

I acknowledge receipt of the Environmental Health inspection report number 1031231093 of 04/24/23.

Certified Food Protection Manager: Najma M Adan

Certification Number: FM109208 Expires: 12/28/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

Najma M Adan
Person in Charge

Signed: _____

Chris Foster
Public Health Sanitarian I
Freeman Office Building
651-983-8760
chris.j.foster@state.mn.us

Report #: 1031231093

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Environmental Health
Food, Pools, and Lodging
625 Robert St. N
St. Paul

No. of RF/PHI Categories Out	1	Date	04/24/23
No. of Repeat RF/PHI Categories Out	0	Time In	10:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Thrive Better	2518 Washington Street NE	Minneapolis, MN	55418	

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0041193		Full		

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		
2	(IN) OUT N/A		
Employee Health			
3	(IN) OUT		
4	(IN) OUT		
5	(IN) OUT		
Good Hygenic Practices			
6	IN OUT (N/O)		
7	(IN) OUT N/O		
Preventing Contamination by Hands			
8	IN OUT (N/O)		
9	IN OUT N/A (N/O)		
10	IN (OUT)		
Approved Source			
11	(IN) OUT		
12	IN OUT N/A (N/O)		
13	(IN) OUT		
14	IN OUT (N/A) N/O		
Protection from Contamination			
15	(IN) OUT N/A N/O		
16	(IN) OUT N/A		
17	(IN) OUT		

	Compliance Status	COS	R
Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)		
19	IN OUT N/A (N/O)		
20	IN OUT N/A (N/O)		
21	IN OUT N/A (N/O)		
22	IN OUT (N/A)		
23	IN OUT N/A (N/O)		
24	IN OUT N/A (N/O)		
Consumer Advisory			
25	IN OUT (N/A)		
Highly Susceptible Populations			
26	(IN) OUT N/A		
Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)		
28	(IN) OUT		
Conformance with Approved Procedures			
29	IN OUT (N/A)		

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

			COS	R
Safe Food and Water				
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	X	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		

			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 & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	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	X	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:** 04/26/23

Inspector (Signature)