DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

December 23, 2022

Licensee
Bethesda North Pointe
500 Peterson Parkway
New London, MN 56273

RE: Project Number(s) SL38113015

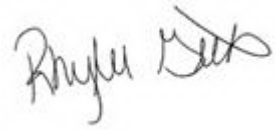
Dear Licensee:

On November 21, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 7, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Rhylee Gilb, Supervisor
Health Regulation Division
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: rhylee.gilb@state.mn.us
Phone: 651-201-5977 Fax: 651-215-6894
HHH

Electronically Delivered

October 4, 2022

Administrator
Bethesda North Pointe
500 Peterson Parkway
New London, MN 56273

RE: Project Number(s) SL38113015

Dear Administrator:

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 evaluation on September 7, 2022, for the purpose assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing 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 . . ."

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 imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

In accordance with Minn. Stat. § 144G.20, Subd. 4(a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring - $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000.00

The total amount you are assessed is $6,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 licensing 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 general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general 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

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

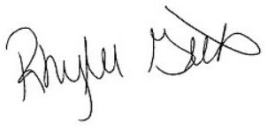
REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



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HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38113	A. BUILDING: _____ B. WING _____	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NORTH POINTE	500 PETERSON PARKWAY NEW LONDON, MN 56273

(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 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: SL38113015 On September 6, 2022, through September 7, 2022, the Minnesota Department of Health (MDH) conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey there were 67 residents receiving services under the provider's Provisional Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 230 SS=C	144G.18 NOTIFICATION OF CHANGES IN INFORMATION	0 230		

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0 230	Continued From page 1 A provisional licensee or licensee shall notify the commissioner in writing prior to a change in the manager or authorized agent and within 60 calendar days after any change in the information required in section 144G.12, subdivision 1, paragraph (a), clause (1), (3), (4), (17), or (18). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to notify the commissioner prior to a change in the facility agent. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The facility was licensed as a provisional assisted living facility with dementia care. The facility agent who received emails and communication from Minnesota Department of Health (MDH) left employment with the facility in February 2022. The facility did not change the agent's name and contact information with MDH. On September 6, 2022, at 11:00 a.m., regional director of housing (RDH)-D confirmed the facility agent listed on the MDH website was not employed by the facility since February 2022. On September 7, 2022, at 1:00 p.m., RDH-D provided a copy of a notification of change	0 230		

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0 230	Continued From page 2 document which had been provided to MDH. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 230		
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: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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	0 480		

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0 480	Continued From page 3 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 September 6, 202, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control related to COVID-19.	0 510		

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0 510	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: HAND HYGIENE (HH) The licensee failed to ensure staff performed hand hygiene per the Centers for Disease Control (CDC) and Minnesota Department of Health (MDH) guidelines. The CDC undated website page titled, Hand Hygiene in Healthcare Settings, indicated healthcare personnel (HCP) should use an alcohol-based hand rub or wash with soap and water for the following indications: immediately before touching a patient (resident), before performing an aseptic task; before moving from work on a soiled body site to a clean body site on the same resident, after touching a resident or resident's immediate environment, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. Healthcare facilities should require HCP to perform HH in accordance with CDC recommendations. On September 7, 2022, at 8:36 a.m., the state surveyor and unlicensed personnel (ULP)-G entered R8's room to observe ULP-G administer three medications to R8. ULP-G stated R8 had three medications to be administered at 8:30 a.m., and several additional medications to be	0 510		

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0 510	Continued From page 5 administered at 9:00 a.m. ULP-G was observed applying a pair of gloves prior to entering R8's room. ULP-G walked out of R8's room still wearing gloves after completing R8's medication administration. ULP-G removed his gloves and disposed them in a small trash bin located across the hallway from R8's room. ULP-G was not observed to perform HH after glove removal. On September 7, 2022, at 8:53 a.m., the state surveyor followed ULP-G to R6's room to observe ULP-G apply R6's thrombo-embolus deterrent (TED) hose stockings. R6 was sitting in his wheelchair in his studio apartment. ULP-G applied new pair of gloves and performed R6's temperature and oxygen saturation checks. After taking R6's vital signs, ULP-G picked up R6's TED hose and kneeled down in front of ULP-G to apply the hose. ULP-G and the state surveyor observed an open, round wound, approximately 2" x 1.5" in diameter on R6's left kneecap, along with two fluid-filled blisters on R6's left foot and below left knee. ULP-G told R6 he was unable to apply the TED hose due to R6's wounds. ULP-G stated he would leave to find a nurse to assess R6's wounds. ULP-G did not perform HH before and after removing his gloves and leaving R6's room. Review of ULP-G's annual performance evaluation dated August 16, 2022, indicated ULP-G was reminded to wash hands before and entering resident's rooms. On September 7, 2022, at 10:20 a.m., registered nurse (RN)-E stated she was in charge of infection control. The licensee policy titled, Hand Hygiene, dated August 1, 2021, indicated HH would be	0 510		

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0 510	Continued From page 6 performed between resident cares and whenever direct physical contact with a resident takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated; (a) before and after direct contact with a resident; (b) moving from a contaminated body site to a clean body site during resident cars; (c) after contact with environmental surfaces or equipment in immediate vicinity of a resident; (d) after removing gloves or gowns; (e) before eating and after using a restroom. TIME PERIOD TO CORRECT: Seven (7) days.	0 510		
0 630 SS=F	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 interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the	0 630		

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0 630	Continued From page 7 person's risk of abusing other vulnerable adults; and statement of specific measures to be taken to minimize the risk of abuse to the person and other vulnerable adults for six of eight residents (R1, R3, R4, R5, R6, R8) with records reviewed, and failed to address listed vulnerabilities with specific interventions for all six residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: R1 R1's diagnoses included atherosclerosis, subarachnoid hemorrhage due to ruptured aneurysm, and memory impairment. R1's service plan dated November 10, 2021, indicated the resident received services which included, housekeeping, laundry and assistance with bathing, and grooming. R1's assessment dated May 5, 2022, indicated R1 had prostate cancer resulting in a permanent indwelling foley catheter which R1 manages with the assistance of a home care agency. R1's Individual Abuse Prevention Plan (IAPP) dated November 10, 2021, identified areas of vulnerability with interventions and a review of the resident's risk to abuse other vulnerable adults. R3's IAPP did not include a review of the resident's risk of being abused by other vulnerable adults and no interventions.	0 630		

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0 630	Continued From page 8 R3 R3's service plan dated February 28, 2022, indicated the resident received services which included, housekeeping, laundry and assistance with bathing, and transferring. R3's assessment dated March 7, 2022, indicated R3 had severe cognitive impairment and had dementia without behavioral disturbances. R3's IAPP dated November 17, 2021, identified areas of vulnerability with interventions and a review of the resident's risk to abuse other vulnerable adults. R3's IAPP did not include a review of the resident's risk of being abused by other vulnerable adults and no interventions. On September 7, 2022, at 3:10 p.m., registered nurse (RN)-E confirmed R1, and R3's IAPP did not include the assessment or review of the resident's risk of being abused by other vulnerable adults. R4 R4's medical record was reviewed. R4 admitted to the facility on November 5, 2021. R4's diagnoses included squamous cell carcinoma of right lower lobe lung, emphysema, Wernicke-Korsakoff syndrome, and encephalopathy. R4's service plan dated August 11, 2022, indicated R4 received assistance with personal cares, safety checks six times per day, medication management, and laundry. R4 used a wheeled walker for mobility. R4's IAPP dated September 7, 2022. indicated R4 had listed vulnerabilities of impaired judgement and difficulty using a telephone. No	0 630		

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0 630	Continued From page 9 additional vulnerabilities were listed on R4's IAPP. R4's IAPP lacked evidence an individualized review or assessment was developed that assessed R4's susceptibility to abuse by another individual, including other vulnerable adults; the risk of abusing other vulnerable adults; and statement of specific measures to be taken to minimize the risk of abuse to R4 and other vulnerable adults. In addition, R4's IAPP lacked specific interventions for R4's listed vulnerabilities. R5 R5's medical record was reviewed. R5 admitted to the facility on October 27, 2021. R5's diagnoses included macular degeneration, diabetes, peripheral neuropathy, and transient ischemic attack (TIA). R5's service plan dated May 5, 2022, indicated R5 received assistance with personal cares, medication management, recording her blood glucose checks, and laundry. R5's IAPP dated September 7, 2022, indicated R5 was assessed as not having any current risk factors for abuse. Staff would observe and report to the nurse any risk factors identified by their vulnerability assessment training. R5's IAPP lacked evidence an individualized review or assessment was developed that assessed R5's susceptibility to abuse by another individual, including other vulnerable adults; the risk of abusing other vulnerable adults; and statement of specific measures to be taken to minimize the risk of abuse to R5 and other vulnerable adults. In addition, R5's IAPP lacked specific interventions for R5's listed	0 630		

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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
0 630	Continued From page 10 vulnerabilities. R6 R6's medical record was reviewed. R6 admitted to the facility on August 31, 2022. R6 resided in an area of the facility where residents required more assistance with cares. R6's diagnoses included diabetes with diabetic autonomic neuropathy, chronic kidney disease (CKD) Stage 3, weakness, and fatigue. R6's service plan dated September 7, 2022, indicated R6 received assistance with personal cares, leg elevation and escorts three times per day, compression stockings, medication management, safety checks, skin checks, housekeeping, and laundry. R6 used a wheelchair and wheeled walker for mobility. R6's IAPP dated September 7, 2022, indicated R6 was assessed as had a balance problem and decreased muscular coordination when he walked. R6 needed physical help in an emergency. R6 expereienced pain on a daily basis. R6 had bilateral pitting edema (+2) on his lower legs, and bilateral pitting edema (+4) on his feet. R6 required assistance in removing clutter from his apartment. R6 was not at risk for being abused. R6's IAPP lacked evidence an individualized review or assessment was developed that assessed R6's susceptibility to abuse by another individual, including other vulnerable adults; the risk of abusing other vulnerable adults; and statement of specific measures to be taken to minimize the risk of abuse to R6 and other vulnerable adults. In addition, R6's IAPP lacked specific interventions for R6's listed vulnerabilities.	0 630		

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	38113	A. BUILDING: _____ B. WING _____	09/07/2022

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0 630	Continued From page 11 R8 R8's medical record was reviewed. R8 admitted to the facility on January 25, 2022. R8's diagnoses included chronic congestive heart failure, and adjustment disorder with anxiety. R8's service plan dated January 25, 2022, indicated R8 received assistance with personal cares, medication management, safety checks four times per day, housekeeping, and laundry. R8 used a wheeled walker for mobility. R8's IAPP dated September 7, 2022, indicated R8 had an unknown risk of abusive behaviors. R8's family denied R8 had any abusive behaviors. R8's IAPP lacked evidence an individualized review or assessment was developed that assessed R8's susceptibility to abuse by another individual, including other vulnerable adults; the risk of abusing other vulnerable adults; and statement of specific measures to be taken to minimize the risk of abuse to R8 and other vulnerable adults. In addition, R8's IAPP lacked specific interventions for R8's listed vulnerabilities. On September 7, 2022, at 3:10 p.m. RN-E acknowledged resident IAPP's lacked the required content, stating the facility was working on the issue. The licensee's Vulnerable Adults, Maltreatment policy dated August 1, 2021, noted the suspected maltreatment situation must be reported immediately. The policy noted the IAPP would contain an individualized review or assessment of the person's risk of being abused by other vulnerable adults.	0 630		

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0 630	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 630		
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 activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has 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 the potential to affect a large portion or all residents). The findings include: On September 6, 2022, from approximately 10:38 a.m. to 12:27 p.m., survey staff toured the facility with Regional Director of Housing (RDH-D). During the facility tour, survey staff observed the facility fire safety and evacuation plan documentation was requested and was noted to lack the following. 1. The schedule and required records on training of employees on fire safety and evacuation. 2. The schedule and required records on training of residents who can assist their own evacuation on proper actions to take in the event of a fire for their safety including movement, evacuation, and relocation. 3. Fire Safety and evacuation plans shall be readily available within the facility. On September 6, 2022, at approximately 12:15	0 810		

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0 810	Continued From page 14 p.m. RDH-D was not able to provide the information listed above as requested. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01620 SS=G	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 observation, interview and record	01620		

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01620	Continued From page 15 review, the licensee failed to ensure the registered nurse (RN) performed reassessments for changes in needs for two of eight residents (R5, R6) with records reviewed. 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 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). Findings Include: R5 R5's medical record was reviewed. R5 admitted to the facility on October 27, 2021. R5's diagnoses included macular degeneration, diabetes, peripheral neuropathy, and stroke. R5's service plan dated May 5, 2022, indicated R5 received assistance with personal cares, medication management, recording her blood glucose checks, and laundry. R5's assessment dated July 20, 2022, indicated R5 was assessed as required some assistance with bathing and showering, including getting in and out of the shower. R5 was independent with dressing and dressed appropriately. R5 was independent with transfers and walking. R5 used her wheeled walker when she walked outside of her apartment. R5 reported she required more assistance with her activities of daily living (ADL's) due to feeling more tired and weaker. R5's progress note dated August 7, 2022, at	01620		

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01620	Continued From page 16 11:33 a.m., indicated R5 was found sitting in her recliner wearing only soiled, wet underwear. R5 told a licensed practical nurse (LPN) she could not find her bra. The LPN changed R5's soiled underwear. The LPN wrote, "R5 needed maximum assistance with dressing. Noted to be unsteady with transferring to a standing position." R5 appeared "very" confused. R5's gait was slow as the LPN escorted R5 down to the dining room. R5 was given food and administered her medications. The LPN wrote she would continue to monitor R5. R5's progress note lacked evidence an RN assessed R5 after her increased confusion and weakness. R5's progress note dated August 7, 2022, at 9:57 p.m., indicated R5 hallucinated about a child in her room. Staff redirected R5 back to her room and assisted her to bed. R5's progress note lacked evidence an RN was notified of R5's hallucinations. R5's progress note dated August 7, 2021, at 11:05 p.m., and written by RN-E, indicated RN-E received a phone call from staff indicating R5 fell in the hallway near her apartment. R5 appeared confused and was not using her wheeled walker at the time of her fall. R5 had no injuries other than a small scrape on her elbow. RN-E called 911. R5 was transported to a local hospital. R5's progress note dated August 10, 2022, at 11:35 a.m., indicated R5 returned to the facility on August 9, 2022. R5 was hospitalized for the fall, increased confusion, and an electrolyte imbalance. R5 reported she still felt, "blah," and still saw "things," stating she saw a boy in her	01620		

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apartment, and occasionally saw children. R5 struggled finding words. R5 was alert and oriented and denied pain.

R5's record lacked evidence an RN performed a fall assessment on R5 after she returned back to the facility.

R5's progress note dated August 19, 2022, at 8:54 p.m., indicated R5 had moderate coughing. R5 appeared confused and did not know where her room was.

R5's progress note lacked evidence an RN performed an assessment on R5 after staff noticed R5's moderate coughing and increased confusion.

R6
R6's medical record was reviewed. R6 admitted to the facility on August 31, 2022. R6 resided in an area of the facility where residents required more assistance with cares. R6's diagnoses included diabetes with diabetic autonomic neuropathy, chronic kidney disease (CKD) Stage 3, weakness, and fatigue.

R6's admission assessment, dated August 31, 2022, indicated R6 experienced two falls in the last three months. R6's assessment indicated R6 needed "some" help with bathing, showering, and getting dressed. R6 required assistance with getting in and out of the shower. R6 required assistance of one staff person when transferring from a seated position to a wheelchair.

R6's progress note dated August 31, 2022, at 7:46 p.m., indicated R6 needed total assistance from two unlicensed personnel (ULP) with bathing and dressing. The note indicated R6 was unable

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to support much weight and nearly fell off the bed. R6 was partially on the bed, lost his balance but was caught by a ULP.

R6's record lacked evidence an RN reassessed R6 after his increased physical assistance.

R6's progress note dated September 4, 2022, at 11:00 a.m., and written by LPN-C, indicated ULP found R6 lying on the floor inside his apartment after they responded to his call pendant. LPN-C arrived and asked R6 why he was on the floor. R6 stated he always stretched his back on the floor. LPN-C asked R6 to get himself back into his chair so she could evaluate him. At first, R6 was unable to get himself up off the floor, and refused LPN-C's request for an ambulance. R6 requested an EZ-Stand lift to assist him off the floor. LPN-C told R6 the facility did not use EZ-Stands for falls, and stated EZ-Stands were only used to assist residents when in a seated or standing position. The note indicated R6 laid on the floor for 45-60 minutes before he was able to get himself into his wheelchair. R6 reopened an abrasion on his left knee. R6 denied he fell, and indicated he was doing well.

R6's record lacked evidence an RN reassessed R6 after he was found on the floor.

R6's service plan dated September 7, 2022, indicated R6 received assistance with personal cares, leg elevation three times per day, compression stockings, medication management, escorts, safety checks four times per day, skin checks, housekeeping, and laundry. R6 used a wheel chair and wheeled walker for mobility.

On September 7, 2022, at 8:53 a.m., state surveyor #2 observed an open red wound on R6's

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01620	Continued From page 19 left kneecap. R6 stated he went down on the floor, "a little too fast." R6 stated on September 4, 2022, night staff discovered his wound after he fell, and alerted LPN-C. R6's wound measured 2.5" x 1.5." In addition, R6 had two fluid-filled blisters located on top on his left foot (2.0" x 1.5"), and underneath his left kneecap (1.0" x 0.5"). LPN-C stated RN-E requested R6's compression stocking remain off. LPN-C stated, "we might have to put an ace wrap on it later." R6's record lacked evidence RN-E assessed R6's left leg. On September 6, 2022, at 1:33 p.m., RN-E stated the RN's performed several assessments, including change-in-condition and falls. On September 7, 2022, at 3:10 p.m., RN-E stated R5 and R6 were not reassessed. The licensee policy titled, Initial and On-Going Nursing Assessment of Residents Under the Comprehensive Licensed Agency, updated August 1, 2022, indicated the RN would complete initial, 14-day, 90-day, and assessments related to a change in the resident's condition. The RN would complete assessments as indicated by individual resident circumstances. The licensee policy titled, Reporting, Docoumenting, and Reviewing Incidents Involving Residents, updated August 1, 2022, indicated the RN would complete an assessment of the resident in a timeframe that was reasonable following the incident. TIME PERIOD TO CORRECT: Seven (7) days.	01620		

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01640	Continued From page 20	01640		
01640 SS=D	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. (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, 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 interview and record review, the licensee failed to ensure all services were provided and implemented as directed in the current service plan for one of eight residents (R6) with records reviewed. 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	01640		

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residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

Findings include:

R6's medical record was reviewed. R6 admitted to the facility on August 31, 2022. R6 resided in an area of the facility where residents required more assistance with cares. R6's diagnoses included diabetes with diabetic autonomic neuropathy, chronic kidney disease (CKD) Stage 3, weakness, and fatigue.

R6's assessment dated September 2, 2022, indicated R6 was assessed as being a fall risk. R6 required transfer assistance of one staff person. R6 required assistance with applying his compression stockings in the morning and removing them at night. R6 had bilateral, pitting, lower leg edema (+2), and bilateral feet edema (+4). R6's lower legs were purple in color and cool to the touch.

R6's Individual Abuse Prevention Plan (IAPP), dated September 7, 2022, indicated R6 had balance issues when he walked.

R6's service plan dated September 7, 2022, indicated R6 received assistance with leg elevation and escorts three times per day, and morning and evening compression stocking application and removal. R6 used a manual wheelchair and wheeled walker for mobility.

R6's Individualized Treatment and Therapy Plan, dated September 7, 2022, indicated instructions for R6's compression stockings included the following: Two times per day, apply compression stockings in the morning. At bedtime, remove

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compression stockings, apply lotion to legs/feet and wash stockings with mild soap; rinse well, towel dry, and hang over shower rod to dry. Observe and notify nurse of any skin irritation or increased swelling. A licensed practical nurse (LPN) supervised R6's application and removal of his compression stockings as ordered by R6's physician.

R6's service delivery record dated September 2022, indicated R6 did not receive his required services for compression stockings, three times per day leg elevation, and escorts on the following dates:

Compression Stockings
9/2/22-7:00 a.m. Reason Indicated: "Doesn't have supplies needed. Nurse knows."

Elevate Legs (Three times per day)
9/1/22- (AM)-Reason Indicated: "Nothing to elevate on." (Midday)-Reason: "Nothing to elevate on."
9/2/22-(AM)-Reason: "nothing to elevate on." (Midday)-Reason: "Nothing to elevate on."
9/5/22-(AM)-Reason: "Nothing to elevate on." (Midday)-Reason: "Nothing to elevate on."
9/6/22-(AM)-Reason: "Nothing to elevate on." (Midday)-Reason: "nothing to elevate on."
9/7/22-(AM)-Reason: "Nothing to elevate on." (Midday)-Reason: "Nothing to elevate on."

Escorts
9/4/22-Reason Indicated: "Walked down himself."

On September 6, 2022, at 1:33 p.m., registered nurse (RN)-E stated service plans were developed and changed as needed by the RN. RN-E stated anyone can let the nurse know if a service plan needed to be changed, stating

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01640	Continued From page 23 unlicensed personnel (ULP) were the front-line workers, helping out multiple times per day. The licensee policy titled, Contents of Service Plans, updated August 1, 2022, indicated the facility would implement and provide all services required by the current service plan unless unable for reasons such as, but not including, resident refusal. TIME PERIOD TO CORRECT: Twenty-one (21) days.	01640		
02310 SS=G	144G.91 Subd. 4 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 care and services were provided according to a suitable and up-to-date plan and subject to accepted health care and medical standards for one of eight residents (R6) with records reviewed. Staff refused to assist R6 off the floor after they found him lying on the floor in his apartment. R6 laid on the floor for almost an hour before he was able to self-transfer himself to his wheelchair. 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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38113	A. BUILDING: _____ B. WING _____	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NORTH POINTE	500 PETERSON PARKWAY NEW LONDON, MN 56273

(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
02310	Continued From page 24 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: R6's medical record was reviewed. R6 admitted to the facility on August 31, 2022. R6 resided in an area of the facility where residents required more assistance with cares. R6's diagnoses included diabetes with diabetic autonomic neuropathy, chronic kidney disease (CKD) Stage 3, weakness, and fatigue. R6's admission assessment, dated August 31, 2022, indicated R6 experienced two falls in the last three months. R6's assessment indicated R6 needed "some" help with bathing, showering, and getting dressed. R6 required assistance with getting in and out of the shower. R6 required assistance of staff person when transferring from a seated position to a wheelchair. R6's service plan dated September 7, 2022, indicated R6 received assistance with personal cares, leg elevation and escorts three times per day, compression stockings, medication management, safety checks four times per day, skin checks, housekeeping, and laundry. R6 used a wheel chair and wheeled walker for mobility. R6's progress note dated September 4, 2022, at 11:00 a.m., and written by licensed practical nurse (LPN)-C, indicated ULP found R6 lying on the floor inside his apartment after they responded to his call pendant. LPN-C arrived and asked R6 why he was on the floor. R6 stated he always stretched his back on the floor. LPN-C asked R6 to get himself back into his chair so she	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38113	A. BUILDING: _____ B. WING _____	09/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NORTH POINTE	500 PETERSON PARKWAY NEW LONDON, MN 56273

(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
02310	Continued From page 25 could evaluate him. At first, R6 was unable to get himself up off the floor, and refused LPN-C's request for an ambulance. R6 requested LPN-C use an EZ-Stand lift to assist him off the floor. LPN-C told R6 the facility did not use EZ-Stands for falls, and stated EZ-Stands were only used to assist residents from a seated or standing position. The note indicated R6 laid on the floor for 45-60 minutes before he was able to get himself into his wheelchair. R6 reopened an abrasion on his left knee. R6 denied he fell, and indicated he was doing well. On September 6, 2022, at 11:25 a.m., registered nurse (RN)-E stated EZ-Stands were utilized in the enhanced living area of the facility. On September 6, 2022, at 1:33 p.m., RN-E stated EZ-Stands required two staff to operate the lift. EN-E stated the facility currently did not have any residents who required using an EZ-Stnad. The licensee lacked a policy on falls. TIME PERIOD TO CORRECT: Seven (7) days.	02310		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/06/22*
Time: 11:45:16
Report: 7930221140

Food and Beverage Establishment Inspection Report

Location:
Bethesda North Pointe
500 Peterson Parkway
New London, MN56273
Kandiyohi County, 34

Establishment Info:
ID #: 0034567
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: (320)354-8501
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.

3-500D Microbial Control: disposition of food

3-501.18A ** Priority 1 **

MN Rule 4626.0405A Discard all TCS food prepared in the establishment or opened commercially packaged food when the time exceeds 7 days from the preparation or opening date or if the container or package is not marked.

DISCARD TUNA DATED 8/28/22 (LOCATED IN THE MAIN PREP COOLER).

Corrected on Site

4-500 Equipment Maintenance and Operation

4-501.114C3 ** Priority 1 **

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

AT TIME OF INSPECTION THE CONCENTRATION OF THE MAIN SANITIZER BUCKET MEASURED 50PPM. DUMP AND REMIX.

Corrected on Site

7-200 Toxic Supplies and Applications

7-201.11A ** Priority 1 **

MN Rule 4626.1600A Separate poisonous or toxic materials from food, equipment, utensils, linens, and single-service and single-use articles by spacing or partitioning.

SANITIZING SPRAY BOTTLE (LABELED DISINFECTANT) WAS STORED ON TOP OF THE ICE MACHINE AT TIME OF INSPECTION. STORE IN A CHEMICAL STORAGE AREA.

Comply By: 09/06/22

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

3-302.12

MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from orginal packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

LIKE STATED ABOVE FOR BINS OF FLOUR, SUGAR AND PANKO.

Comply By: 09/06/22

4-900 Protecting Clean Items

4-904.13

MN Rule 4626.0975 Protect preset tableware from contamination by wrapping, covering or inverting. Remove exposed preset tableware that is unused when a customer is seated or clean and sanitize exposed preset tableware that is not removed when a customer is seated.

LIKE STATED ABOVE. AT TIME OF INSPECTION THE SILVERWARE WAS SET ON TOP OF THE NAPKINS.

Comply By: 09/06/22

6-200 Physical Facility Design and Construction

6-202.14

MN Rule 4626.1390 Provide necessary walls and ceiling to completely enclose toilet rooms and a tight-fitting, self-closing device on the toilet room door.

PROVIDE A SELF-CLOSING DEVICE ON THE RESTROOM DOOR IN THE KITCHEN. AT TIME OF INSPECTION THERE WAS NOT A SELF-CLOSING DEVICE ON THE DOOR.

Comply By: 09/20/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 50PPM at Degrees Fahrenheit
Location: MAIN SANITIZER BUCKET--FIRST TEST
Violation Issued: Yes

Quaternary Ammonia: = 200PM at Degrees Fahrenheit
Location: MAIN SANITIZER BUCKET--SECOND TEST
Violation Issued: No

Hot Water: = at 171.9 Degrees Fahrenheit
Location: DISHWASHER FINAL RINSE CYCLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Prep Cooler
Temperature: 41 Degrees Fahrenheit - Location: SLICED TOMATOES
Violation Issued: No

Process/Item: Hot Holding
Temperature: 208 Degrees Fahrenheit - Location: CHICKEN PATTY
Violation Issued: No

Type: Full
Date: *09/06/22*
Time: 11:45:16
Report: 7930221140
Bethesda North Pointe

Food and Beverage Establishment Inspection Report

Process/Item: Prep Cooler
Temperature: 41 Degrees Fahrenheit - Location: TUNA
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: WHIPPED CREAM--UPRIGHT NEAR DEEP FRYER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK--UPRIGHT NEAR DISH ROOM
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: CUCUMBER SALAD
Violation Issued: No

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

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 7930221140 of 09/06/22.

Certified Food Protection Manager: Mark B. Smith

Certification Number: FM111162 Expires: 05/03/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Tina Remmele
Tina Remmele, R.S.
Environmental Health Specialist
St. Cloud District Office
320-223-7302
tina.remmele@state.mn.us

Report #: 7930221140

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	2	Date	09/06/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:45:16
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Bethesda North Pointe	500 Peterson Parkway	New London, MN	56273	(320)354-8501

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0034567		Full		H

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	X	
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	X	
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

			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		Thermometers provided & accurate		
Food Identification				
37	X	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	X	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		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	X	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:** 09/06/22

Inspector (Signature) Tina Remmle