



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

December 13, 2024

Licensee  
Benedict Homes  
1340 Minnesota Boulevard Southeast  
Saint Cloud, MN 56304

RE: Project Number(s) SL20286016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 6, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

### **STATE CORRECTION ORDERS**

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

### **DOCUMENTATION OF ACTION TO COMPLY**

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

### **CORRECTION ORDER RECONSIDERATION PROCESS**

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

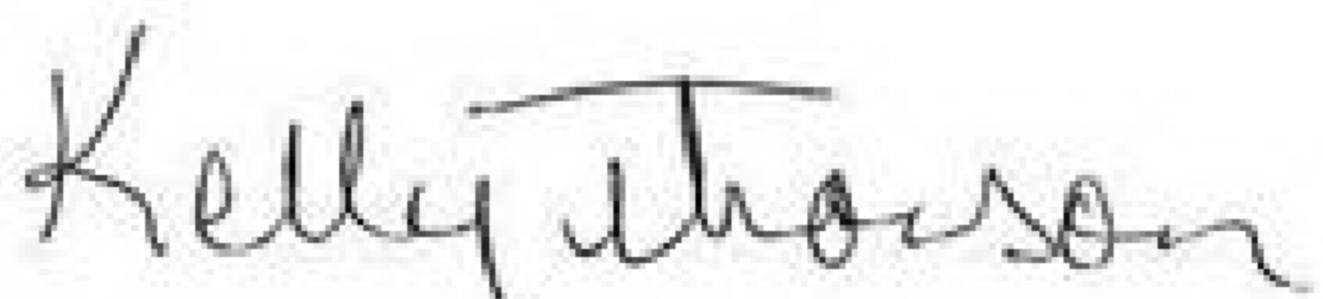
**<https://forms.web.health.state.mn.us/form/HRDAppealsForm>**

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at [susan.winkelmann@state.mn.us](mailto:susan.winkelmann@state.mn.us) or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Kelly Thorson, Supervisor  
State Evaluation Team  
Email: [kelly.thorson@state.mn.us](mailto:kelly.thorson@state.mn.us)  
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20286</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BENEDICT HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1340 MINNESOTA BOULEVARD SE SAINT CLOUD, MN 56304</b>
---	---

(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	<p><b>Initial Comments</b></p> <p><b>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p><b>INITIAL COMMENTS:</b></p> <p><b>SL# 20286016</b></p> <p>On November 4, 2024, through November 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 20 resident(s); 20 receiving services under the Assisted Living Facility with Dementia Care license.</p>	0 000	<p>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.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p><b>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.</b></p>	
0 480 SS=F	<b>144G.41 Subd 1 (13) (i) (B) Minimum requirements</b>	0 480		

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20286</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BENEDICT HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1340 MINNESOTA BOULEVARD SE SAINT CLOUD, MN 56304</b>
---	---

(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
0 480	<p>Continued From page 1</p> <p>(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</p> <p>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.</p> <p>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).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 4, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p> <p>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.</p>	0 480		
01620 SS=D	<p>144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring</p> <p>(c) Resident reassessment and monitoring must be conducted no more than 14 calendar days</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20286</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BENEDICT HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1340 MINNESOTA BOULEVARD SE SAINT CLOUD, MN 56304</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	<p>Continued From page 2</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing client assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for one of two residents (R3).</p> <p>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</p>	01620		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20286</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/06/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BENEDICT HOMES</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1340 MINNESOTA BOULEVARD SE SAINT CLOUD, MN 56304</b>
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	<p>Continued From page 3</p> <p>situation has occurred only occasionally).</p> <p>On November 4, 2024, at 10:20 a.m., during the entrance conference, clinical nurse supervisor (CNS)-B stated an RN completed assessments pre-admission, within 14 days, every 90 days, and with changes in condition.</p> <p>R3 began receiving services on January 14, 2024.</p> <p>R3's record indicated 90-day comprehensive nursing assessments were completed on July 3, 2024, and October 18, 2024, 107 days apart.</p> <p>On November 6, 2024, at 2:05 p.m., CNS-B stated an RN completes reassessments every 90 days and she was not aware that this assessment was completed late.</p> <p>The licensee's Initial and Ongoing Nursing Assessment of Clients policy dated August 2019, indicated the RN will reassess the client and update the service plan based on the client's needs and at a frequency not to exceed 90 days from the last date of the assessment.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-One (21) days</p>	01620		



Minnesota Department of Health  
Food, Pools, and Lodging  
PO Box 64975  
St. Paul, MN 55164  
651-201-4500

Type: Full  
Date: 11/04/24  
Time: 11:00:03  
Report: 1046241264

## Food and Beverage Establishment Inspection Report

Page 1

### Location:

Benedict Homes  
1340 Minnesota Boulevard Se  
St Cloud, MN56304  
Sherburne County, 71

### Establishment Info:

ID #: 0039156  
Risk:  
Announced Inspection: No

### License Categories:

Expires on: / /

### Operator:

Phone #: 3202520010  
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.

### 4-900 Protecting Clean Items

#### 4-903.11B

MN Rule 4626.0955B Store all clean equipment and utensils in a self-draining position that permits air drying, and covered or inverted.

OBSERVED MOISTURE IN BETWEEN STACKED CUPS IN THE SERVING KITCHEN. ALLOW CUPS TO FULLY AIR DRY BEFORE STACKING.

Comply By: 11/04/24

### Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit

Location: BUCKET IN SERVING KITCHEN

Violation Issued: No

Hot Water: = at 165.2 Degrees Fahrenheit

Location: DISHWASHER FINAL RINSE

Violation Issued: No

### Food and Equipment Temperatures

Process/Item: Hot Holding

Temperature: 189 Degrees Fahrenheit - Location: CHICKEN BREAST

Violation Issued: No

Process/Item: Hot Holding

Temperature: 135 Degrees Fahrenheit - Location: MASHED POTATOES

Violation Issued: No

Type: Full  
Date: 11/04/24  
Time: 11:00:03  
Report: 1046241264  
Benedict Homes

# Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler  
Temperature: 38 Degrees Fahrenheit - Location: SOUR CREAM  
Violation Issued: No

---

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

---

FOOD IS CATERED IN FROM THE "CARE CENTER" (MAIN CAMPUS BUILDING). FOOD IS TEMPED UPON ARRIVAL, PLACED INTO STEAM TABLES, AND THEN PLATED BY EMPLOYEES AND PASSED TO RESIDENTS. DISHES ARE WASHED ONSITE IN THE DISHWASHER, AND SERVING TRAYS ARE BROUGHT BACK TO THE "CARE CENTER" FOR CLEANING.

DISCUSSED HANDWASHING, NOROVIRUS, AND EXCLUSION OF ILL EMPLOYEES FROM WORK. WILL SEND FACT SHEETS WITH REPORT.

**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 1046241264 of 11/04/24.


Certified Food Protection Manager: Jennifer M. Goff

Certification Number: 56324 Expires: 07/21/26

**Inspection report reviewed with person in charge and emailed.**

Signed: \_\_\_\_\_

Establishment Representative

Signed:  \_\_\_\_\_

Nicole Larrison  
Public Health Sanitarian  
St. Cloud  
320-472-0042  
nicole.larrison@state.mn.us

Report #: 1046241264

# Food Establishment Inspection Report



**Minnesota Department of Health**  
**Food, Pools, and Lodging**  
 PO Box 64975  
 St. Paul, MN 55164

No. of RF/PHI Categories Out: 0

Date: 11/04/24

No. of Repeat RF/PHI Categories Out: 0

Time In: 11:00:03

Legal Authority MN Rules Chapter 4626

Time Out

Benedict Homes	Address 1340 Minnesota Boulevard Se	City/State St Cloud, MN	Zip Code 56304	Telephone 3202520010
License/Permit # 0039156	Permit Holder	Purpose of Inspection Full	Est Type	Risk Category

## FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

IN= in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS=corrected on-site during inspection

R= repeat violation

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

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

**Risk factors (RF)** are improper practices or procedures 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

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

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

Food Recalls:

Person in Charge (Signature)

Date: 11/04/24

Inspector (Signature)