Electronically Delivered

March 11, 2025

Licensee
Central Minnesota Senior Care
1008 South 10th Street
Brainerd, MN 56401

RE: Project Number(s) SL20683016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 11, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20683	A. BUILDING: _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MINNESOTA SENIOR CARE	1008 SOUTH 10TH STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20683016-0 On February 10, 2025, through February 11, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were six residents; six receiving services under the Assisted Living Facility.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 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 ensure infection control standards were followed for one of two employees (unlicensed personnel (ULP)-F) during resident treatments and cares. 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: On February 11, 2025, at 9:05 a.m., the surveyor observed ULP-F apply hand sanitizer and gloves. ULP-F cleaned R2's suprapubic (SP-a flexible tube that drains urine from the bladder through a small incision in the lower abdomen) catheter port, irrigated R2's bladder via the SP catheter port, and attached a catheter leg bag to R2's SP	0 510		

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0 510	Continued From page 2 catheter port. With the same gloved hands, ULP-F assisted R2 with changing R2's brief, pants, and ULP-F proceeded to assist R2 with washing R2's face then R2's peri area. With the same gloved hands, ULP-F removed tape and a soiled gauze dressing from around R2's SP catheter, cleansed R2's SP catheter site with an alcohol swab, applied a topical medication to a clean gauze dressing, placed the gauze dressing around R2's SP catheter site, and secured the gauze with tape. ULP-F removed ULP-F's gloves and without performing hand hygiene assisted R2 with changing R2's shirt. On February 11, 2025, at 9:45 a.m., ULP-F stated ULP-F did not perform hand hygiene or glove changes throughout R2's morning cares. ULP-F further stated ULP-F was trained to wash hands after completing all cares with a resident. In addition, ULP-E stated ULPs were trained to complete hand hygiene between resident cares and with glove changes. On February 11, 2025, at 10:00 a.m., clinical nurse supervisor (CNS)-B stated ULPs were trained to change gloves and complete hand hygiene during cares that the ULP may be exposed to blood or bodily fluids. CNS-B further stated the licensee conducted monthly audits of hand hygiene and provided direct verbal education to ULPs with any concerns. The licensee's undated Infection Control Practices policy indicated 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. In addition, the	0 510		

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0 510	Continued From page 3 policy indicated to wash hands after the removal of gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 700 SS=D	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of six resident's (R2) personal health and medical information was kept private. 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:	0 700		

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0 700	Continued From page 4 On February 11, 2025, at 8:50 a.m., the surveyor with unlicensed personnel (ULP)-F observed labels on cabinets in the large, shared bathroom. R2's label had written R2's first and last name along with "Cath (catheter) Care." ULP-F stated all residents used the shared bathroom and R2's cabinet had always been labeled with what supplies were inside of R2's cabinet. On February 11, 2025, at 10:02 a.m., clinical nurse supervisor (CNS)-B stated R2's label should probably not have contained R2's full name or listed what was inside R2's cabinet, however, CNS-B would have to review the licensee's HIPPA (Health Insurance Portability and Accountability Act) policy to be sure. The licensee's undated Confidentiality Policy indicated all information regarding individuals the licensee serves and information pertaining to the conduct of the company's business must be kept confidential. The licensee's undated HIPAA policy indicated health information be handled with strong consideration for minimum necessary disclosure. The policy further indicated under HIPPA, all health care entities are required to develop and document security programs to guard Protected Health Information (PHI). PHI is information in any format (paper, electronic or verbal) that personally identifies an individual we (the licensee) serve. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		

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0 775	Continued From page 5	0 775		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to comply with the Minnesota State Fire Code, under Minnesota Rules Chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On February 10, 2025, at 11:10 a.m., the surveyor toured the facility licensed assisted living director (LALD)-A. During the tour, the surveyor observed the following: Emergency Exits: - An exit sign was posted at a side door on the main floor leading out to the backyard. An exit path was not maintained free of snow from this door to the public right of way. - The door leading from the dining room to the back patio was labaled as an emergency exit route on the floor and escape plan. An exit path was not maintained free of snow from this door to	0 775		

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0 775	Continued From page 6 the public right of way. - An exit sign was posted at the basement door. Stairs led from this door up to the yard. An exit path was not maintained free of snow from the top of the stairs to the public right of way. All paths of egress must provide unobstructed exiting for the building occupants and access for emergency responders in the event of an emergency. A means of egress shall be free from obstructions that would prevent its use, including snow. - The posted floor and escape plans did not label the exit doors. Exit labels are required to be included on the floor plan in order to direct occupants to the exits in the event of an emergency. Carbon Monoxide Alarms: Carbon monoxide alarms were not installed within ten feet of resident sleeping rooms. The fire alarm system inspection report dated January 6, 2025, did not list carbon monoxide devices on the report. When carbon monoxide alarms are not tied into the building fire alarm system, carbon monoxide alarms are required to be installed within ten feet of all sleeping rooms. Physical Environment Maintenance: - One wall panel was loose between the attached garage and the facility. The wall between the attached garage and the facility must be maintained to ensure proper fire separation. - There was an accumulation of lint behind the clothes dryer in the laundry room, creating a fire hazard. - One emergency light in the basement did not work when tested by LALAD-A. Emergency lights must be maintained to ensure proper operation in the event of an emergency. - The labeled one hour fire door in the basement	0 775		

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0 775	Continued From page 7 at the base of the stairs was held open with a wedge. Devices used to hold open fire doors must not prohibit the required operation and closing feature of the door. - In the basement furnace room, the labeled fire door was held open by a box. Drywall was missing from the lower areas of the walls enclosing the mechanical room. Where labeled fire doors are installed, the room must be maintained to compartmentalize smoke and flames. During the tour interview, LALD-A verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01760		

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01760	Continued From page 8 review, the licensee failed to ensure medications were administered per prescriber orders for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During the entrance conference on February 10, 2025, at 10:17 a.m., registered nurse (RN)-C stated the licensee provided medication management services to residents at the facility. R1 was admitted to the facility on August 28, 2023, and received assisted living services. R1's diagnoses included Parkinson's disease (disorder of the central nervous system that affects movement), depression, hypothyroidism (thyroid gland does not produce enough thyroid hormone), and diabetes. R1's Service Plan (Waiver) dated October 28, 2024, indicated R1 received med (medication) assist (assistance) nine times daily. R1's prescriber order dated January 20, 2025, included an order for levothyroxine (used to treat hypothyroidism) 175 micrograms (mcg) taking one tablet Monday to Saturday and one and one-half tablets on Sunday.	01760		

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01760	Continued From page 9 On February 10, 2025, at 11:46 a.m., the surveyor observed unlicensed personnel (ULP)-D complete scheduled medication administration for R1. R1's medication administration record (MAR) dated February 2025, indicated levothyroxine 175 mcg take one tablet daily for hypothyroidism, however, R1's MAR lacked levothyroxine 175 mcg take one and one-half tablets on Sunday. On February 11, 2025, at 10:52 a.m., RN-C stated the levothyroxine on R1's February MAR was a transcription error and did not reflect R1's current levothyroxine order or what the resident had received. On February 11, 2025, at 10:57 a.m., clinical nurse supervisor (CNS)-B stated the pharmacy dispensed R1's levothyroxine 175 mcg one tablet daily Monday through Saturday and one and one-half tablets on Sunday. CNS-B further stated the levothyroxine was a transcription error for Sunday's dosage written on R1's February 2025 MAR. The licensee's undated Medication Management policy indicated the medication management record must be current and updated when there are any changes. In addition, the provider will facilitate communication with the prescriber, pharmacist, and client/resident and client representative/legal and designated representatives, as appropriate if any problem arises with medication management services by use of verbal, written, or through utilization of telecommunication methods based on practice standards that meet the individual client/resident needs [sic].	01760		

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01760	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the steps of the treatment administration process was followed for one of two employees (unlicensed personnel (ULP)-F) observed administering treatments. 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: During the entrance conference on February 10, 2025, at 10:35 a.m., registered nurse (RN)-C	02320		

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02320	Continued From page 11 stated the licensee provided treatments to residents at the facility, including catheters. R2's diagnosis included cognitive impairment, chronic obstructive pulmonary disease (COPD-difficult breathing), and Suprapubic catheter (SP-a flexible tube that drains urine from the bladder through a small incision in the lower abdomen). R2's Service Plan (Waiver)- Addendum to Contract dated December 10, 2024, indicated R2 received suprapubic cleansing twice daily. R2's Treatment and Therapy Plan dated February 7, 2025, indicated staff to cleanse R2's SP catheter site with soap and water two times daily and apply split sponge. R2's Treatment Administration Record (TAR) dated January 2025, and February 2025, respectively, indicated cleanse R2's SP catheter insertion sites with soap and water twice daily and apply split sponge. On February 11, 2025, at 9:05 a.m., the surveyor observed ULP-F conduct a scheduled treatment administration for R2's SP catheter. ULP-F removed tape and a soiled gauze dressing from around R2's SP catheter, cleansed R2's SP catheter site with an alcohol swab, applied a topical medication to a clean gauze dressing, placed the clean gauze dressing around R2's SP catheter site, and secured the gauze with tape. On February 11, 2025, at 9:44 a.m., ULP-F stated ULP-F used an alcohol swab to cleanse R2's SP catheter site instead of using soap and water that was listed on R2's TAR dated February 2025.	02320		

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	20683	A. BUILDING: _____ B. WING _____	02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL MINNESOTA SENIOR CARE	1008 SOUTH 10TH STREET BRAINERD, MN 56401

(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
02320	Continued From page 12 On February 11, 2025, at 10:03 a.m., clinical nurse supervisor (CNS)-B stated ULPs were instructed to cleanse R2's SP catheter site with soap and water per the instructions on R2's TARs and an alcohol swab should not have been used to cleanse R2's SP catheter site. The licensee's undated Treatment and Therapy Management policy indicated individualized treatment and therapy management record for each client/resident would include documentation of specific client/resident instructions relating to the treatments or therapy administration for ULPs to follow. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Type: Full
Date: *02/10/25*
Time: 10:58:49
Report: 1037251044

Food and Beverage Establishment Inspection Report

Location:
Central Minnesota Senior Care
1008 10th S S
Brainerd, MN56401
Crow Wing County, 18

Establishment Info:
ID #: 0039307
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2188284823
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = 167 at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 36 Degrees Fahrenheit - Location: PACKAGED SHREDDED LETTUCE
Violation Issued: No

Process/Item: Cooking
Temperature: 189 Degrees Fahrenheit - Location: CHILI
Violation Issued: No

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

DISCUSSED BARE HAND CONTACT, COOLING, REHEATING, EMPLOYEE ILLNESS RECORDING, AND MENU.
BARE HAND CONTACT AND COOLING FACT SHEETS LEFT ONSITE.

Type: Full
Date: *02/10/25*
Time: 10:58:49
Report: 1037251044
Central Minnesota Senior Care

Food and Beverage Establishment Inspection 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 1037251044 of 02/10/25.

Certified Food Protection Manager: KIRA M HAARUP

Certification Number: 113241 Expires: 09/15/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
JENNIE

Signed: Michelle L Hovanes
Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037251044

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 02/10/25
Time In 10:58:49
Time Out

Central Minnesota Senior Care	Address: 1008 10th S S	City/State: Brainerd, MN	Zip Code: 56401	Telephone: 2188284823
License/Permit #: 0039307	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

		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			
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			
Warewashing facilities: installed, maintained, & used; test strips			
49			
Non-food contact surfaces clean			
Physical Facilities			
50			
Hot & cold water available; adequate pressure			
51			
Plumbing installed; proper backflow devices			
52			
Sewage & waste water properly disposed			
53			
Toilet facilities: properly constructed, supplied, & cleaned			
54			
Garbage & refuse properly disposed; facilities maintained			
55			
Physical facilities installed, maintained, & clean			
56			
Adequate ventilation & lighting; designated areas used			
57			
Compliance with MCIAA			
58			
Compliance with licensing & plan review			

Food Recalls:

Person in Charge (Signature) **Date:** 02/10/25

Inspector (Signature) Michelle L Hoveras