



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 3, 2025

Licensee
Carriage House Senior Living
175 East Derrynene Street
Le Center, MN 56057

RE: Project Number(s) SL35876016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 4, 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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 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.

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

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor

State Evaluation Team

Email: jodi.johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35876	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER CARRIAGE HOUSE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 175 EAST DERRYNENE STREET LE CENTER, MN 56057			
(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: SL35876016-0 On March 3, 2025, through March 4, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 18 residents; 18 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 4, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480			

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	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 glove use and handwashing during AM cares for one of one resident (R2). 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:	0 510			

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0 510	Continued From page 4 R2's Service Plan signed November 7, 2024, indicated R2 received assistance with dressing, grooming, bathing, toileting/incontinence care, and applying/removing thrombo embolic deterrent (TED) stockings (compression stockings used to increase circulation and decrease swelling). On March 4, 2025, at 7:53 a.m., the surveyor observed unlicensed personnel (ULP)-D assisting R2 with morning cares. ULP-D donned gloves and assisted with transferring R2 into the bathroom onto the toilet. ULP-D asked R2 if she wanted to get dressed in the bathroom or in the bedroom; R2 opted for the bathroom. ULP-D then doffed and disposed of gloves in wastebasket, and asked R2 what she wanted to wear. ULP-D obtained R2's clothes and also made R2's bed. ULP-D then returned to the bathroom, donned clean gloves, wet a clean washcloth and handed to R2 to wash her face. When R2 was finished, ULP-D rinsed and wrung the washcloth out and thoroughly washed underneath R2's pannus stomach overhang and dried thoroughly with a clean dry towel. ULP-D changed gloves, rinsed out R2's top denture and handed to R2 to put it in. ULP-D then removed and disposed gloves, removed R2's nightgown, applied deodorant to the resident, then assisted with putting on her dress. ULP-D then applied R2's compression stockings and non-skid stockings, put on a clean incontinence brief, donned clean gloves, and assisted R2 with standing so she could perform pericare. After finishing pericare, ULP-D pulled up R2's incontinence brief, adjusted R2's dress, and assisted R2 to transfer with her walker into her wheelchair. ULP-D then doffed/disposed of gloves and moved R2 into her bedroom. ULP-D then applied R2's hearing aids, brushed her hair	0 510			

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0 510	Continued From page 5 and put it into a ponytail. ULP-D then transported R2 in her wheelchair to the dining room for breakfast. After positioning R2 at the dining table, ULP-D returned to R2's room to straighten up and obtain garbage and dirty laundry. The surveyor interviewed ULP-D at that time and asked at what point she would wash her hands. ULP-D stated she washed her hands prior to going into R2's room and would wash them again once she was finished. ULP-D stated knowing she should be cleansing hands in between glove changes, but R2's room has no paper towels in the bathroom for her to utilize. ULP-D further stated the only hand sanitizer available on that side of the building was on the counter between the dining room and the kitchen. On March 4, 2025, at 12:50 p.m., clinical nurse supervisor (CNS)-B stated with this being the resident's "home" she would expect staff to cleanse hands when entering the resident's room and after leaving the resident's room. With glove use, they would expect that staff go from clean to dirty. CNS-B stated if staff needed to change gloves, they would be able to wash their hands but wouldn't have anything to dry them with because there were no paper towels in the majority of the resident rooms. CNS-B further stated feeling that having a paper towel dispenser in resident bathrooms would not be home like. The licensee's 8.09 Hand Washing policy dated May 16, 2024, indicated: Hand Hygiene and Gloves When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. No further information provided.	0 510			

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0 510	Continued From page 6	0 510			
0 680 SS=F	TIME PERIOD FOR CORRECTION: Seven (7) days 144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. This had the potential	0 680			

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0 680	Continued From page 7 to affect all residents, staff and visitors at the assisted living facility license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: The licensee's Emergency Preparedness binder lacked the following required content: - conduct exercises to test EP at least twice per year, including unannounced staff drills using EP, including participating in an annual full-scale exercise community based or annual individual facility based functional exercise or if facility experiences an actual emergency requiring evacuation of plan, facility is exempt from engaging in its next required full scale exercise; conduct an additional annual exercise that may include a second full scale exercise community based or an individual; facility based functional exercise or mock disaster drill or table top exercise. On March 4, 2025, at 4:06 p.m., licensed assisted living director (LALD)-A stated they had completed emergency preparedness trainings/drills or had actual events utilizing the plan, but they did not have documentation to support this. The licensee's 4.01 Training, Exercises, and Testing policy effective/revised March, 11, 2024,	0 680			

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0 680	Continued From page 8 indicated staff will participate in a full-scale exercise that is community based, or when a community based exercise is not accessible, an individual, facility-based tabletop exercise. If the facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for one year following the actual event. The facility will also conduct an additional annual exercise that may include, but is not limited to the following: A second full-scale exercise that is community-based or individual, facility-based; or; A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed message, or prepared questions designed to challenge an emergency plan; or; A mock disaster drill. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the	0 775			

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0 775	Continued From page 9 potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On March 4, 2025, from 11:00 a.m. to 2:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the surveyor observed that hard-wired emergency exit lights did not illuminate when tested. Emergency lights had not received annual service since 2016, lights are located in the hallway near the kitchen, the dining room area, and in the East wing near resident room 12. Fire code requires in the event of power supply failure in rooms and spaces that require two or more means of egress an emergency electrical system shall automatically illuminate. Facility has a fuel-fired furnace in a mechanical room behind the kitchen with no carbon monoxide alarms in the facility. Fire code states, carbon monoxide detection be provided in dwelling units, sleeping units and classrooms located in buildings that contain fuel burning appliances or fuel-burning fireplaces. Delayed/controlled egress doors throughout the	0 775			

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0 775	Continued From page 10 facility, surveyor asked LALD-A the location of the switch or device that unlocks all doors. A signal or switch to unlock the egress doors was not found or was not known by staff. Fire code states, egress control locking system shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock. During a facility tour on March 4, 2025, at 1:30 a.m., LALD-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 775			
0 780 SS=D	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except	0 780			

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NAME OF PROVIDER OR SUPPLIER CARRIAGE HOUSE SENIOR LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 175 EAST DERRYNENE STREET LE CENTER, MN 56057			
(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
0 780	Continued From page 11 that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life and failed to keep the facility in compliance with the Minnesota Fire Code. This had the potential to directly affect all of the residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On March 4, 2025, from 11:00 a.m. to 2:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, surveyor observed that hard-wired smoke alarms did not interconnect with other smoke alarm in resident unit 4/5. Unit was being used as a suite and the smoke alarms shall interconnect. Smoke alarms interconnect so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate. These deficient conditions were visually verified	0 780			

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0 780	Continued From page 12 by LALD-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) day.	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and 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 potential to affect a large portion or all of the residents). The findings include:	0 790			

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0 790	Continued From page 13 On March 4, 2025, from 11:00 a.m. to 2:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour, the portable fire extinguisher cabinets throughout the facility lacked access. Fire extinguisher cabinets had a glass front, which states "break to open" there was no tool on the cabinet to break the glass. Delayed access to portable fire extinguishers allows fire growth, increasing heat and smoke endangers the life of all occupants. On March 4, 2025, at 1:00 p.m., LALD-A, verified this deficient finding. TIME PERIOD FOR CORRECTION: Two (2) days.	0 790			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810			

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0 810	Continued From page 14 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. 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 potential to affect a large portion or all of the residents). The findings include: On March 4, 2025, from 11:00 a.m. to 2:30 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A. During the tour surveyor observed the posted evacuation plans	0 810			

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0 810	Continued From page 15 lacked identification of resident rooms. On March 4, 2025, LALD-A provided documents on the fire safety and evacuation plan (FSEP), fire safety training and evacuation drills, for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire Safety", dated July 24, 2024, failed to include the following: RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. TRAINING: The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. Staff does web-based training at the time of hire, LALD-A stated they were using evacuation drills as training. No other training documentation was provided. The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. On February 11, 2025, at 12:30 p.m., LALD-D stated they understood the requirements for training staff and would implement a training program that was compliant with statute requirements.	0 810			

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0 810	Continued From page 16	0 810			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct	01500			

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01500	Continued From page 17 support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-E). 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).	01500			

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01500	Continued From page 18 The findings include: ULP-E was hired to provide direct care services for the licensee on January 18, 2022. On March 4, 2025, at 8:27 a.m., the surveyor observed ULP-E administering medication to R1. ULP-E's employee record lacked evidence the employee had successfully completed annual training as required, to include the following: - training on reporting of maltreatment of vulnerable adults under section 626.557; - review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; and - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On March 4, 2025, at 3:32 p.m., licensed assisted living director (LALD)-A stated being unable to locate evidence the above required annual trainings were completed by ULP-E. The licensee's 5.06 Annual Required Staff Training policy dated April 18, 2024, indicated: The following training elements MUST be included every 12 months to all staff who performs direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights	01500			

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01500	Continued From page 19 and staff responsibilities related to ensuring the exercise and protection of those rights 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;	01540			

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01540	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one direct care employee (unlicensed personal (ULP)-E) received the required annual dementia training for each 12 months of employment. 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: ULP-E was hired to provide direct care services under the assisted living with dementia care license on January 18, 2022. On March 4, 2025, at 8:27 a.m., the surveyor observed ULP-E administering medication to R1. ULP-E's employee record lacked evidence of completing two hours of dementia training for each 12 months of employment prior to the start of the survey. On March 4, 2025, at 3:32 p.m. licensed assisted living director (LALD)-A stated being unable to locate evidence the required annual dementia training was completed by ULP-E. The licensee's 5.03 Dementia Training policy dated April 18, 2024, indicated all staff are required to complete dementia training at the time	01540			

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01540	Continued From page 21 of hire and annually thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01540			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed by one of one unlicensed personnel (ULP-E) observed during medication administration for R4. 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	01750			

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01750	Continued From page 22 situation has occurred only occasionally). The findings include: R4's Service Plan signed September 17, 2024, indicated services included medication and treatment administration. R4's physician orders dated July 25, 2024, included an order for diclofenac gel (topical non-steroidal anti-inflammatory drug for arthritis discomfort) apply four grams topically to lower back four times daily. On March 4, 2025, at 7:46 a.m., the surveyor observed ULP-E administer medications to R4 including diclofenac gel. ULP-E donned gloves then squeezed approximately a quarter sized amount of the diclofenac gel into her gloved hand then applied to R4's lower back. On March 4, 2025 at 9:28 a.m., ULP-E stated she hadn't really been trained on how to measure out ointment when a specific dose is ordered. ULP-E further stated some ointment did include a measuring device with the packaging. On March 4, 2025, at 12:50 p.m., clinical nurse supervisor (CNS)-B stated although diclofenac gel was available over the counter, it should still be measured according the the provider's order. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated April 19, 2024, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [The Licensee] will ensure that the registered nurse has: 1. Instructed the ULP in the proper methods with respect to each resident to administer the	01750			

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01750	Continued From page 23 medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures. 2. Specified in writing specific instructions for each resident and documented those instructions in the resident's records 3. Communicated with the ULP about the individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced	01910			

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01910	Continued From page 24 by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medication including the medication's prescription number as applicable, for one of one discharged resident (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The discharge resident roster provided by the licensee indicated R3 was admitted on March 28, 2024, and discharged on July 31, 2024, to his home residence. R3's Service Plan signed June 5, 2024, indicated R3 received medication administration. R3's Medications - Current form dated July 29, 2024, included medications that had been sent with the resident. The document identified the medication name, strength, quantity, and signature of the licensee's staff that counted the medications and the person receiving the medications. The document did not include the prescription number for any of the identified medications including aspirin, atorvastatin (for high cholesterol), baclofen (muscle relaxant), docusate sodium enema (constipation), and metformin (diabetes).	01910			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35876	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER CARRIAGE HOUSE SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 175 EAST DERRYNENE STREET LE CENTER, MN 56057		
(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
01910	Continued From page 25 On March 4, 2025, at 11:14 a.m., licensed practical nurse (LPN)-C stated when sending medications with a resident upon discharge they did not include the prescription number. LPN-C further stated they only documented the prescription number when destroying medications. The licensee's 7.23 Medication Disposal policy dated April 19, 2024, indicated: Unused Prescription Drugs: Current unused medications managed by [licensee name] will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the residents medications are no longer managed by the facility or the medication has been discontinued by the prescriber. Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35876	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER CARRIAGE HOUSE SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 175 EAST DERRYNENE STREET LE CENTER, MN 56057		
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01950	Continued From page 26 delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-F) demonstrated competency in compression stockings to a RN. 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 March 3, 2025, at 10:33 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment and therapy services including assistance with compression stockings.	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35876	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER CARRIAGE HOUSE SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 175 EAST DERRYNENE STREET LE CENTER, MN 56057		
(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
01950	Continued From page 27 ULP-F was hired on June 6, 2024, to provide direct care services to the residents. ULP-F's employee record lacked competencies for compression stockings (thrombo embolic deterrent (TED)). On March 4, 2025, at 12:50 p.m., CNS-B stated ULP-F assisted with TED stocking removal and was unable to locate evidence of completing competency to the RN. The licensee's 5.02 Competency Training Evaluations policy dated April 18, 2024, indicated: 7. Additional nursing tasks that are frequently delegated to unlicensed personnel that would require training and competency testing by a RN include: TED stockings 11. A copy of all education, training, and competency testing shall be kept in each employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the	02040			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35876	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER CARRIAGE HOUSE SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 175 EAST DERRYNENE STREET LE CENTER, MN 56057		
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02040	Continued From page 28 assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct mitigation for hazard vulnerability or safety risk assessment on or around the facility property. 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 residents). The findings include: During record review on March 4, 2025, from 11:00 a.m. to 2:30 p.m., with licensed assisted living director (LALD)-A. The licensee failed to provide mitigation for the hazards on the hazard vulnerability assessment (HVA). Facility did have a HVA completed with percentages assigned to each vulnerability, the assessment was missing mitigation's to take when and if those hazards happened. On March 4, 2025, at 12:30 p.m. LALD-A stated they understood the requirements and would implement mitigation's for hazards identified on HVA.	02040			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 35876	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER CARRIAGE HOUSE SENIOR LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 175 EAST DERRYNENE STREET LE CENTER, MN 56057		
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02040	Continued From page 29 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040			

Type: Full
Date: 03/04/25
Time: 11:30:00
Report: 1033251105

Food and Beverage Establishment Inspection Report

Page 1

Location:

Carriage House Senior Living
175 East Derrynene Street
Le Center, MN56057
Le Sueur County, 40

Establishment Info:

ID #: 0038080
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073570100
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.

4-500 Equipment Maintenance and Operation

4-502.11B

**** Priority 2 ****

MN Rule 4626.0820B Calibrate food temperature measuring devices in accordance with manufacturer's specifications as often as necessary to ensure accuracy.

Dial thermometer probe is measuring 110 degrees F at room temperature. Person in charge discarded probe.
Corrected on Site

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 original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.

Oil bottle does not have a label. Person in charge labeled the bottle.
Corrected on Site

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

Wood cabinets are degrading and must be replaced. Wall near mop sink is damaged.
Comply By: 06/03/25

Surface and Equipment Sanitizers

Type: Full
Date: 03/04/25
Time: 11:30:00
Report: 1033251105
Carriage House Senior Living

Food and Beverage Establishment Inspection Report

Page 2

Quaternary Ammonium: = 400PPM at Degrees Fahrenheit
Location: Red Bucket
Violation Issued: No

Hot Water: = at 161 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: Tomatoes-Cooler
Violation Issued: No

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Two Door Freezer
Violation Issued: No

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Process/Item: Cooking
Temperature: 187 Degrees Fahrenheit - Location: Pork Patties-Flat Top
Violation Issued: No

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

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

I acknowledge receipt of the inspection report number 1033251105 of 03/04/25.

Certified Food Protection Manager: Teresa Lyn Bruley

Certification Number: FM110729 Expires: 04/01/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Teresa Lyn Bruley

Signed: 
Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us

Report #: 1033251105		Food Establishment Inspection Report													
		No. of RF/PHI Categories Out			0	Date 03/04/25									
		No. of Repeat RF/PHI Categories Out			0	Time In 11:30:00									
		Legal Authority MN Rules Chapter 4626				Time Out									
Carriage House Senior Living		Address 175 East Derrynene Street		City/State Le Center, MN		Zip Code 56057	Telephone 5073570100								
License/Permit # 0038080		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	Compliance Status		COS	R						
Supervision				Time/Temperature Control for Safety											
1	IN	OUT	PIC knowledgeable; duties & oversight			18	IN	OUT	N/A	N/O	Proper cooking time & temperature				
2	IN	OUT	N/A	Certified food protection manager, duties			19	IN	OUT	N/A	N/O	Proper reheating procedures for hot holding			
Employee Health				Consumer Advisory											
3	IN	OUT	Mgmt/Staff;knowledge,responsibilities&reporting			20	IN	OUT	N/A	N/O	Proper cooling time & temperature				
4	IN	OUT	Proper use of reporting, restriction & exclusion			21	IN	OUT	N/A	N/O	Proper hot holding temperatures				
5	IN	OUT	Procedures for responding to vomiting & diarrheal events			22	IN	OUT	N/A		Proper cold holding temperatures				
Good Hygienic Practices				Highly Susceptible Populations											
6	IN	OUT	N/O	Proper eating, tasting, drinking, or tobacco use			25	IN	OUT	N/A	Consumer advisory provided for raw/undercooked food				
7	IN	OUT	N/O	No discharge from eyes, nose, & mouth			Food and Color Additives and Toxic Substances								
Preventing Contamination by Hands				Food and Color Additives and Toxic Substances											
8	IN	OUT	N/O	Hands clean & properly washed			26	IN	OUT	N/A	Pasteurized foods used; prohibited foods not offered				
9	IN	OUT	N/A	N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed			27	IN	OUT	N/A	Food additives: approved & properly used			
10	IN	OUT		Adequate handwashing sinks supplied/accessible			28	IN	OUT		Toxic substances properly identified, stored, & used				
Approved Source				Conformance with Approved Procedures											
11	IN	OUT		Food obtained from approved source			29	IN	OUT	N/A	Compliance with variance/specialized process/HACCP				
12	IN	OUT	N/A	N/O	Food received at proper temperature			Risk factors (RF) are improper practices or proceeedures 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.							
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											
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					COS	R				
Safe Food and Water				Proper Use of Utensils											
30	IN	OUT	N/A	Pasteurized eggs used where required			43		In-use utensils: properly stored						
31			Water & ice obtained from an approved source			44		Utensils, equipment & linens: properly stored, dried, & handled							
32	IN	OUT	N/A	Variance obtained for specialized processing methods			45		Single-use/single service articles: properly stored & used						
Food Temperature Control				Utensil Equipment and Vending											
33			Proper cooling methods used; adequate equipment for temperature control			46		Gloves used properly							
34	IN	OUT	N/A	N/O	Plant food properly cooked for hot holding			47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used					
35	IN	OUT	N/A	N/O	Approved thawing methods used			48		Warewashing facilities: installed, maintained, & used; test strips					
36	X		Thermometers provided & accurate	X		49		Non-food contact surfaces clean							
Food Identification				Physical Facilities											
37	X		Food properly labeled; original container	X		50		Hot & cold water available; adequate pressure							
Prevention of Food Contamination				Physical Facilities											
38			Insects, rodents, & animals not present			51		Plumbing installed; proper backflow devices							
39			Contamination prevented during food prep, storage & display			52		Sewage & waste water properly disposed							
40			Personal cleanliness			53		Toilet facilities: properly constructed, supplied, & cleaned							
41			Wiping cloths: properly used & stored			54		Garbage & refuse properly disposed; facilities maintained							
42			Washing fruits & vegetables			55	X	Physical facilities installed, maintained, & clean							
Food Recalls:				Date: 03/04/25											
Person in Charge (Signature)															
Inspector (Signature)															