Electronically Delivered

October 21, 2024

Licensee
New Hope Care LLC
7949 Orchard Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL36973015

Dear Licensee:

On October 9, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 30, 2024, survey were corrected. This follow-up survey verified that the facility is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

August 26, 2024

Licensee
New Hope Care LLC
7949 Orchard Avenue North
Brooklyn Park, MN 55443

RE: Project Number(s) SL36973015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 30, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted no 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.

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.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. 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,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36973	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE CARE LLC	7949 ORCHARD AVENUE NORTH BROOKLYN PARK, MN 55443

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36973015-0 On July 29, 2024, through July 30, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) resident(s); 4 receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on July 29, 2024, issued for SL36973015-0, tag identification 1290. On July 30, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.	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 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 29, 2024, 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 to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place	0 550		

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0 550	Continued From page 2 information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care (OOLTC) and Office of Ombudsmen for Mental Health and Developmental Disabilities. This had the potential to affect all four (4) residents receiving assisted living services. 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 July 29, 2024, at approximately 11:45 a.m.,	0 550		

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0 550	Continued From page 3 the surveyor observed the common areas of the facility lacked a posting of the grievance procedure and OOLTC contact information. On July 29, 2024, at approximately 11:45 a.m., licensed assisted living director (LALD)-A acknowledged the grievance procedure was not posted and stated they thought that the information was posted. The licensee's undated Complaint and Investigation Process policy did not address the posting of the complaint process or the required contents of the posting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by:	0 640		

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0 640	Continued From page 4 Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to 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). The findings include: On July 29, 2024, at approximately 11:45 a.m., the surveyor observed the facility's common areas lacked the following required postings: - posting of 911emergency number in common areas and near telephones provided by the assisted living facility; and - posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On July 29, 2024, at approximately 11:45 a.m., licensed assisted living director (LALD)-A acknowledged the common areas lacked the required postings for MAARC reporting and 911 information. LALD-A stated they thought the information was posted. The licensee's undated Reporting Maltreatment	0 640		

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0 640	Continued From page 5 of Vulnerable Adult policy indicated the facility would support protection and safety by: -posting the 911 emergency number in common areas and near telephones; and -posting information and the reporting number for MAARC to report suspected maltreatment of a vulnerable adult. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers	0 660		

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0 660	Continued From page 6 for Disease Control and Prevention (CDC) which included baseline testing for three of three employees (unlicensed personnel (ULP)-C, ULP-D, 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's facility TB risk assessment dated April 5, 2024, indicated the facility was a low risk setting for TB transmission. ULP-C ULP-C was hired October 6, 2021, and began providing assisted living services. ULP-C's employee record included a TB history and symptom screen dated October 26, 2021. ULP-C's employee record lacked a tuberculin skin test (TST) or a TB blood test. ULP-D ULP-D was hired on November 29, 2021, and began providing assisted living services. ULP-D's employee record included a TB history and symptom screen dated November 29, 2021. ULP-D's employee record lacked a TST or a TB blood test.	0 660		

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0 660	Continued From page 7 ULP-E ULP-E was hired on March 9, 2022, and began providing assisted living services. ULP-E's employee record included a TB history and symptom screen dated March 9, 2022. ULP-E's employee record also included a two-step TST given on September 16, 2019, and repeated on September 19, 2019. ULP-E's TB test was completed greater than 90 days prior to employment with licensee. On July 29, 2024, at approximately 2:00 p.m., licensed assisted living director (LALD)-A stated he did not know where the test results were located and stated all employee were required to take a TB test when they were hired. LALD-A also stated they were unaware TB results needed to be completed less than 90 days prior to employment. On July 30, 2024, at approximately 1:30 p.m., LALD-A stated ULP-C had taken her TB test the prior day. The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated baseline TB screening is required for all healthcare workers. The document also read "an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker)	0 660		

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0 660	Continued From page 8 starts working with patients. Baseline TB screening should be documented in the employee's record." The licensee's undated Tuberculosis Screening policy indicated each employee having direct contact with residents must have documentation of baseline health symptom screening prior to providing care to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	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	0 680		

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0 680	Continued From page 9 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 (EPP) with all the required content. This had the potential to affect all residents of the assisted living licensee. 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 licensee's emergency disaster preparedness plan, reviewed August 1, 2023, lacked evidence of the following required content: - identification of at-risk population needs; - policies addressing subsistence needs for staff and residents such as food, water, medical supplies and pharmaceutical supplies; - procedures for tracking of staff and patients; - policies and procedures for evacuation of residents and staff; - policies and procedures for sheltering in place for residents, staff, and volunteers who remain in the facility; - policies and procedures for medical documents to address preservation of resident information,	0 680		

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0 680	Continued From page 10 protection of confidentiality, and secures/maintains the availability of records; -quarterly review of missing resident plan. - development of a written communication plan which must include: - primary and alternative means for communication; - methods for sharing information on occupancy and needs; and - long-term care (LTC) family notifications. On July 30, 2024, at approximately 2:00 pm, licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated they were not aware of all the requirements of Appendix Z. The licensee's undated Emergency Management policy indicated the facility will have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. The policy includes a reference to Minnesota Statute 144A.4791, Subd. 12. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 790		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 790	Continued From page 11 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 the proper installation and ready access to the portable fire extinguisher located on the upper-level floor. This had the potential to directly affect 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 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 July 30, 2024, from 10:00 a.m. to 11:15 a.m., survey staff toured the home with the licensed assisted living director (LALD)-A. During the tour, survey staff observed the portable fire extinguisher unit on the upper-level floor was located on the floor inside a closet that was padlocked requiring a key to access for use. The LALD-A verified the deficiency finding as the padlock was removed during the home tour. On July 30, 2024, at 11:30 a.m., during an interview, the survey staff explained the deficient condition to the LALD-A, and they understood and acknowledged the finding.	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36973	A. BUILDING: _____ B. WING _____	07/30/2024

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0 790	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of the residents, visitors, 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, 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:	0 800		

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0 800	Continued From page 13 On July 30, 2024, from 10:00 a.m. to 11:15 a.m., survey staff toured the home with the licensed assisted living director (LALD)-A. During the home tour, survey staff observed the following: -The lower-level bathroom toilet seat and cover were loose and not properly secured to the fixture for proper use. When the survey staff opened the toilet cover, both the toilet cover and the seat nearly slid off sideways. The LALD-A stated that they would fix it. -The lavatory drain line inside the cabinet located in the lower-level bathroom had a slow leak. The LALD-A stated they had a plumber look at it and will repair it. -The door on resident sleeping room 1 was damaged and failed to latch when closed for the resident's privacy and for fire and smoke protection during a fire or similar emergency. The finding was evident when the door handle was 2 inches above the latch strike plate so it would not engage when closed. The LALD-A stated they would be replacing the entire door. -The egress windows for the resident sleeping rooms 1 and 3 were not easily and readily operable for immediate use. Survey staff explained to the LALD-A that egress sleeping windows must be easily operable and openable for immediate use. -The patio sliding door was very difficult to open and slide. The LALD-A agreed and stated that he would clean and grease the door. - No approved cigarette butt receptacle for proper disposal of cigarette butts. The finding was evident as survey staff observed an ashtray used to put out cigarette butts on a table on the wood deck. Survey staff asked about the home's designated smoking area and a proper cigarette butt receptacle. The LALD-A verified the finding and stated that they will have a designated area	0 800		

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0 800	Continued From page 14 for smoking off their deck in the backyard and will provide a cigarette butt receptor for proper disposal. The above findings were verbally and/or visually verified by the LALD-A at the time of discovery accompanying the tour. On July 30, 2024, at 11:30 a.m., during an interview, the survey staff explained the deficient findings to the LALD-A, and they understood and acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 15 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document and record review, and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan and the required minimum training of residents on the fire safety and evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 30, 2024, from 10:00 a.m. to 11:15 a.m.,	0 810		

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0 810	Continued From page 16 survey staff toured the home with the licensed assisted living director (LALD)-A. During the tour, survey staff observed the sleeping rooms were labeled with numbers but the fire evacuation diagrams did not include room numbers for each sleeping room. Evacuation plans must include the location and number of residents' sleeping rooms. On July 30, 2024, at approximately 11:30 a.m. document and record review and interview with the licensed assisted living director (LALD)-A, on the home's fire safety and evacuation plan, dated August 1, 2021, indicated the following: -Document review indicated the licensee's fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. During the interview, the LALD-A verified that the fire safety and evacuation plan did not include these provisions. -Document review indicated the licensee's fire safety and evacuation plan did not include and identify in the plan the specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. During the interview, the LALD-A verified that the fire safety and evacuation plan did not include these provisions. -Record review of the available documentation indicated the licensee failed to provide evacuation training to residents who are capable of self-evacuation on the proper actions to be taken in the case of a fire or similar emergency including movement, evacuation, and relocation at least once per year. The LALD-A was unable to provide documentation showing any training	0 810		

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0 810	Continued From page 17 offered to residents on the fire safety and evacuation plan. The above deficient findings were verified by the LALD-A during the interview. On July 30, 2024, at 11:30 a.m., during an interview, the survey staff explained the deficient findings to the LALD-A, and they understood and acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer	0 900		

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0 900	Continued From page 18 contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute an assisted living (AL) contract before offering housing and assisted living services for two of two residents (R1, 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) 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: R1 R1 was admitted on February 1, 2022, and began receiving assisted living services. R1's record included a Service Plan signed and dated February 4, 2022, indicating R1's services included medication administration, meal preparation, and behavior management. R1's record included a Residency Agreement/Assisted Living Contract with R1's	0 900		

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0 900	Continued From page 19 signature dated July 30, 2024 (after initiation of the survey), indicating R1 received housing and AL services prior to the execution of a written contract. R2 R2 was admitted on May 17, 2024, and began receiving assisted living services. R2's record included an unsigned Service Plan dated July 30, 2024, indicating R2's services included medication administration and behavioral management. The record also included a separate Service Agreement page signed and dated on July 30, 2024 (after initiation of the survey). R2's record included a Resident Agreement/Assisted Living Contract signed and dated July 30, 2024 (after initiation of the survey), indicating R2 received housing and services prior to the execution of a written contract. On July 30, 2024, licensed assisted living director (LALD)-A stated R1 and R2 had been receiving housing and services without signed contracts. LALD-A stated residents had previously refused to sign their contract until he told them the state would "shut them down" unless they signed their contract. The licensee's undated Assisted Living Contracts policy indicated the facility would establish a contract with each client at the time of admission to the program. TIME PERIOD TO CORRECT: Twenty-one (21) days	0 900		

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0 910	Continued From page 20	0 910		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2). This had the potential to affect all four residents who received assisted living services. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on February 1, 2022, and began receiving assisted living services. R1's Service Plan dated February 4, 2022,	0 910		

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0 910	Continued From page 21 indicated R1's services included medication administration, meal preparation, and behavior management. R1's Residency Agreement/Assisted Living Contract was signed by the resident on July 30, 2024 (after initiation of the survey). R1's Residency Agreement/Assisted Living Contract lacked the following required information: -the legal name and the health facility identification number of the licensee; and -the name, telephone number, and physical address of the facility, the licensee of the facility, and the managing agent, and authorized agent of the licensee. R2 R2 was admitted on May 17, 2024, and began receiving assisted living services. R2's Service Plan dated July 30, 2024, indicated R2's services included medication administration and behavior management. R2's Residency Agreement/Assisted Living Contract dated July 30, 2024 (after initiation of the survey), lacked the following required information: -the legal name and the health facility identification number of the licensee; and -the name, telephone number, and physical address of the facility, the licensee of the facility, and the managing agent, and authorized agent of the licensee. On July 30, 2024, at 1:30 p.m., licensed assisted living director (LALD)-A stated the same contract was used for all residents and was missing the provider's HFID, legal name, address, phone number, and authorized agent. LALD-A stated they were not aware of the information required in	0 910		

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0 910	Continued From page 22 the contract. The licensee's undated Assisted Living Contracts policy indicated the contract must include: -the legal name and license number of the facility; and -the name, telephone number, and physical mailing address of the facility and licensee, managing agent and authorized agent of the facility. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-one (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be transferred or have housing or services terminated or be subject to an	0 920		

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0 920	Continued From page 23 emergency relocation; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written assisted living contract with the required content for two of two residents (R1, R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted February 1, 2022, and began receiving assisted living services. R1's service plan signed February 4, 2022, indicated R1's services included medication administration, meal preparation, and behavioral management. R1's record contained a Residency Agreement/Assisted Living Contract signed July 30, 2024 (after initiation of the survey), lacked the following required information: -a disclosure that the facility does not hold an assisted living facility with dementia care license; and	0 920		

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0 920	Continued From page 24 -a description of all terms and conditions of the contact, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount. R2 R2 was admitted on May 17, 2024, and began receiving assisted living services. R2's service plan signed July 30, 2024, indicated R2's services included medication administration and behavior management. R2's record contained a Residency Agreement/Assisted Living Contract signed July 30, 2024 (after initiation of the survey), lacked a disclosure that the facility does not hold an assisted living facility with dementia care license. On July 30, 2024, at approximately 1:35 p.m., licensed assisted living director (LALD)-A stated they were unaware of the information required in the contracts. The licensee's undated Assisted Living Contracts policy indicated that contracts must include a description of any limitations to the housing or assisted living services to be provided for the contracted amount. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
01290 SS=I	144G.60 Subdivision 1 Background studies required	01290		

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01290	Continued From page 25 (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) prior to staff providing services for two of two employees (registered nurse (RN)-B and unlicensed personnel (ULP)-D). This had the potential to affect all four residents residing in the assisted living facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	01290		

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	36973	A. BUILDING: _____ B. WING _____	07/30/2024

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01290	Continued From page 26 RN-B RN-B was issued a registered nursing license in the state of Minnesota on June 11, 2013. RN-B was hired on August 17, 2021, and began providing assisted living services. On July 29, 2024, at approximately 10:30 a.m., licensed assisted living director (LALD)-A stated RN-B was the primary nurse for the facility and conducted all resident assessments. On July 29, 2024, at approximately 12:00 p.m., the surveyor observed RN-B working in the facility. ULP-D ULP-D was hired on November 29, 2021, and began providing assisted living services. On July 29, 2024, at approximately 12:00 p.m., ULP-D was on the weekly schedule and the surveyor observed ULP-D working in the facility. On July 29, 2004, at approximately 12:15 p.m., LALD-A logged into NETStudy 2.0 on their phone and surveyor observed that RN-B and ULP-D's background study eligibility had expired. On July 29, 2994, at approximately 12:28 p.m., LALD-A and RN-B stated they were unaware that background studies had expired and required renewal. On July 29, 2024, the Minnesota Department of Human Services website indicated the following: Emergency studies completed during the COVID-19 pandemic were no longer valid. Individuals who only had an emergency study	01290		

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01290	Continued From page 27 must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. The licensee's undated Background Studies policy indicated background studies would be completed on all employees and employees would not work with residents until a cleared background study without a cleared background study. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On July 30, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and	01290		

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01290	Continued From page 28 level remained unchanged.	01290		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing	01470		

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01470	Continued From page 29 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 the challenges it poses to communication; (2) 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 interview and record review, the licensee failed to ensure employees received orientation to include all required content for three of three employees (unlicensed personnel (ULP)-C, ULP-D, 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-C	01470		

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01470	Continued From page 30 ULP-C was hired on October 26, 2021, and began providing assisted living services. ULP-C"s employee record lacked documentation of the following orientation topics required: -consumer advocacy services including information on the Office of the Ombudsman for Long-Term Care, Office of the Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; -a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-D ULP-D was hired on November 29, 2021, and began providing assisted living services. ULP-D's employee record lacked documentation of the following required orientation topics: -a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-E ULP-E was hired on March 9, 2022, and began providing assisted living services. ULP-E's employee record lacked documentation of the following required orientation topics: -consumer advocacy services including information on the Office of the Ombudsman for	01470		

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01470	Continued From page 31 Long-Term Care, Office of the Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; -a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On July 30, 2024, at approximately 1:30 p.m., licensed assisted living director (LALD)-A stated they were unaware that topics were missing from orientation and the program would need to be updated. The licensee's undated Facility Employee Orientation policy indicated orientation topics would include: -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates or other relevant advocacy services; and -a review of the types of services the employee will be providing and the scope of the facility's services under the specific license. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 32 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure revisions to the service plan were authenticated by the licensee and the resident documenting agreement for services to be provided for one of two residents (R1) and failed to finalize a current written service plan within fourteen (14) days after the date that services started for one of two residents (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	01640		

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01640	Continued From page 33 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted February 1, 2024, and began receiving assisted living services. R1's record contained a Service Plan signed February 4, 2022, indicating R1 received the following services: -comprehensive assessment; -re-assessment and monitoring; -medication setup; -meal preparation; -laundry; -shopping; -behavioral management; -housekeeping; -medication administration; and -home health aide supervision. R1's record also contained an unsigned Service Plan dated July 30, 2024, which included the addition of the following services: -activity assistance; -ambulation; -bathing reminder; -bedmaking; -dressing; -linen change; -record temperature; -remove garbage; and -safety check. R1's Service Plan Modification dated July 30, 2024, had been revised and lacked authentication by the facility and resident documenting	01640		

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01640	Continued From page 34 agreement on the services to be provided. R2 R2 was admitted on May 17, 2024, and began receiving assisted living services. R2's record contained an unsigned Service Plan Modification dated July 30, 2024, and a signed Service Agreement/Service Plan dated July 30, 2024 (after initiation of the survey), indicating R2's service plan had not been finalized within 14 days of start of services provided. On July 30, 2024, at approximately 9:30 a.m., licensed assisted living director (LALD)-A stated they were not aware that authentication was required by a facility representative and the resident with any revisions to the service plan. LALD-A also stated R2 had received services since May 17, 2024, and refused to sign a service plan until July 30, 2024. The licensee's undated Service Plan policy indicated the following: -a service plan shall be finalized with each resident no later than 14 calendar days after the start of services; and -the service plan and any revisions must include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting agreement on services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		

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01650	Continued From page 35	01650		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included all required content for two of two residents (R1, R2). This practice resulted in a level two violation (a	01650		

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01650	Continued From page 36 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: R1 R1 admitted on February 1, 2022, and began receiving assisted living services. R1's record contained a Service Plan signed February 4, 2022, which lacked the following required content: -the methods of monitoring assessments of the resident; and -the schedule and methods of monitoring staff providing services. R1's record contained an unsigned Service Plan Modification dated July 30, 2024, which lacked the following required content: -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; -a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -names and contact information of persons the resident wishes to be notified in case of an emergency; and -the circumstance in which emergency services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters.	01650		

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01650	Continued From page 37 R2 R2 was admitted on May 17, 2024, and began providing assisted living services. R2's record included an unsigned Service Plan Modification dated July 30, 2024, which lacked the following required content: -the schedule and methods of monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; -a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -names and contact information of persons the resident wishes to be notified in case of an emergency; and -the circumstance in which emergency services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. On July 30, 2024, at approximately 9:30 a.m., licensed assisted living director (LALD)-A stated they were unaware of the required content of service plans. The licensee's undated Service Plan policy indicated service plans would include the following content: -the schedule and methods for monitoring assessments of the resident; -the schedule and methods of monitoring staff providing services; -a contingency plan for circumstances when services cannot be provided which includes: -the actions to be taken by the provider if scheduled services cannot be provided; -name and contact information of persons the	01650		

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01650	Continued From page 38 resident wishes to have notified in an emergency; -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed initial and annual medication reassessments 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) 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:	01710		

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01710	Continued From page 39 R1 was admitted on February 1, 2022, and began receiving assisted living services. R1's Service Agreement signed February 4, 2022, indicated R1's services included medication management and administration. R1's record lacked an initial or annual medication management assessment. On July 30, 2024, at approximately 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-E administering medications to R1. On July 30, 2024, at approximately 1:53 p.m., clinical nurse supervisor (CNS)-B stated they did not know a medication assessment needed to be completed at least annually. The licensee's undated Individualized Medication Management Plan and Record policy indicated medication management services would be provided based on an individualized assessment and state license requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36973	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE CARE LLC	7949 ORCHARD AVENUE NORTH BROOKLYN PARK, MN 55443

(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
01730	Continued From page 40 facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36973	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE CARE LLC	7949 ORCHARD AVENUE NORTH BROOKLYN PARK, MN 55443

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01730	Continued From page 41 maintain a current individualized medication management record for each resident to include all required content 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) 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: R1 was admitted on February 1, 2022, and began receiving assisted living services. R1's Service Plan signed February 4, 2022, indicated R1's services included medication administration, meal preparation, and behavioral management. R1's record lacked a medication management plan including all required content. On July 30, 2024, at approximately 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-E administering medications to R1. On July 30, 2024, at approximately 1:55 p.m., clinical nurse supervisor (CNS)-B stated they were unaware that a medication management plan was required for residents. The licensee's undated Individualized Medication Management Plan and Record policy indicated the licensee would develop an individualized medication management plan and record based on the nursing assessment and the needs or	01730		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36973	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE CARE LLC	7949 ORCHARD AVENUE NORTH BROOKLYN PARK, MN 55443

(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
01730	Continued From page 42 preferences of the resident. The policy also indicated the Individualized Medication Management Plan would be modified when necessary and modified plans would be signed by the resident or resident's representative. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained for one of two residents (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: R2 was admitted on May 17, 2024, and began	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36973	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE CARE LLC	7949 ORCHARD AVENUE NORTH BROOKLYN PARK, MN 55443

(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
01820	Continued From page 43 receiving assisted living services. R2's Service Plan Modification dated July 30, 2024, indicated R2's services included medication management and administration. R2's Medication Administration Summary for June 2024, indicated R2 was administered the following medications: -cetirizine 10 milligram (mg) tablet, take one by mouth (PO) daily (for allergies); -dapagliflozin 10 mg tablet, take one tablet PO daily (for diabetes); -Invega Sustenna Injection 234 mg/1.5 milliliter (ml); inject monthly (for schizophrenia); -lisinopril 2.5 mg tablet, take three tablets PO daily (for hypertension); -lorazepam 2.5 mg tablet, take one tablet PO at bedtime (for anxiety); -metformin 500 mg tablet, take one tablet PO twice daily (for diabetes); -Nystatin cream, apply topically to affected area two times daily (fungal rash); -ziprasidone 80 mg capsule, take one capsule PO twice daily (for schizophrenia); -zolpidem 10 mg tablet, take one tablet PO at bedtime (for insomnia) -benztropine 0.5 mg tablet, take one tablet PO twice daily as needed (PRN) for muscle rigidity; -docusate sodium 100 mg capsule, take one capsule two times daily PRN for constipation; -hydroxyzine 50 mg capsule, take one capsule PO every six hours PRN for anxiety; -ketoconazole 2% shampoo, use daily PRN for dry scalp; and -polyethylene glycol, take 17 grams PO as needed for constipation. R2's record lacked signed provider orders for the following medications:	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36973	A. BUILDING: _____ B. WING _____	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HOPE CARE LLC	7949 ORCHARD AVENUE NORTH BROOKLYN PARK, MN 55443

(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
01820	Continued From page 44 -Invega Sustenna Injection 234 mg/1.5 ml; inject monthly (for schizophrenia); -metformin 500 mg tablet, take one tablet PO twice daily (for diabetes); -ziprasidone 80 mg capsule, take one capsule PO twice daily (for schizophrenia); -benztropine 0.5 mg tablet, take one tablet PO twice daily as needed (PRN) for muscle rigidity; and -ketoconazole 2% shampoo, use daily PRN for dry scalp. On July 30, 2024, at approximately 9:45 a.m., licensed assisted living director (LALD)-A stated they were not aware prescriber orders were not in the record and he would retrieve them through his phone. The licensee's undated Medication Prescriptions and Refills policy indicated a current written prescriber's prescription must be obtained for any medication, including over-the-counter medication, whenever staff is responsible for setting up the medication, administering the medication, or providing other medication management services for a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=D	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152.	01830		

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	36973	A. BUILDING: _____ B. WING _____	07/30/2024

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NEW HOPE CARE LLC	7949 ORCHARD AVENUE NORTH BROOKLYN PARK, MN 55443

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01830	Continued From page 45 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriptions were renewed at least annually, or every 12 months, for one of five 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: R1 was admitted on February 1, 2022, and began receiving assisted living services. R1's Service Plan signed February 4, 2022, indicated R1's services included medication management and administration. R1's Medication Administration Summary dated June 2024, indicated R1 had been administered the following medications during that month: -multivitamin chewable, take one tablet by mouth (PO) daily (for supplement); -benztropine 1 milligram (mg), take one tablet PO daily (for tremors); -Biktarvy 50/200/25 mg tablet, take one tablet PO daily (for Human Immunodeficiency Virus (HIV)); -carboxymethylcellulose 0.5% solution, place one drop in both eyes four times daily (for dry eyes); -divalproex 250 mg tablet, take three tablets PO daily (to treat seizures);	01830		

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01830	Continued From page 46 -Flovent 44 micrograms (mcg) Inhaler, take one puff two times daily (asthma); -haloperidol injection 100 mg/milliliter (ml), Inject 1 ml intramuscularly every two weeks (for schizophrenia); -hydroxyzine 25 mg tablet, take three tablets PO daily (for anxiety); -spironolactone 100 mg tablet, take 2 tablets PO daily (for hypertension); -Vitamin D3 1000 units (u), take two tablets PO daily (supplement); -estradiol valerate 20 mg/ml, inject 1.5 ml once weekly (hormone therapy); and -trazadone 100 mg, take one tablet at bedtime (insomnia). R1's record lacked a current prescription renewal for the following medications: -multivitamin chewable, take one tablet by mouth (PO) daily (for supplement); -benztropine 1 mg, take one tablet PO daily (for tremors); -Biktarvy 50/200/25 mg tablet, take one tablet PO daily (for HIV); -carboxymethylcellulose 0.5% solution, place one drop in both eyes four times daily (for dry eyes); -Flovent 44 mcg Inhaler, take one puff two times daily (asthma); -haloperidol injection 100 mg/ml, inject 1 ml intramuscularly ever two weeks (for schizophrenia); -hydroxyzine 25 mg tablet, take three tablets PO daily (for anxiety); -spironolactone 100 mg Tablet, take 2 tablets PO daily (for hypertension); -Vitamin D3 1000 u, take two tablets PO daily (supplement); -estradiol valerate 20 mg/ml, inject 1.5 ml once weekly (hormone therapy); and -trazadone 100 mg, take one tablet at bedtime	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01830	Continued From page 47 (insomnia). On July 30, 2024, at approximately 9: 30 a.m., licensed assisted living director (LALD)-A stated they were not aware that current renewed prescriber orders were not in R1's record and that they would retrieve the orders through their phone. The licensee's undated Medication Prescriptions and Refills policy indicated the RN or LPN would assure the prescriber renews a medication order at least every 12 months, or more frequently if determined necessary based on the nursing assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01830		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *07/29/24*
Time: 11:13:09
Report: 7994241139

Food and Beverage Establishment Inspection Report

Location:

New Hope Care Llc
7949 Orchard Avenue North
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:

ID #: 0039196
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632215401
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

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

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW EGGS AND CHICKEN FOUND STORED OVER READY TO EAT FOODS IN FRIDGE. STAFF MOVED RAW FOODS AS LOW AS POSSIBLE IN THE FRIDGE.

Comply By: 07/29/24

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

FRIDGE WAS RECENTLY STOCKED BUT SOME FOODS WERE FOUND ABOVE 41 F. STAFF ADJUSTED FRIDGE AND WILL MONITOR.

Comply By: 07/29/24

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

FACILITY IS CURRENTLY NOT DATE MARKING ALL REQUIRED FOODS. GAVE EXAMPLES OF FOODS THAT REQUIRE DATE MARKING.

Comply By: 07/29/24

Type: Full
Date: *07/29/24*
Time: 11:13:09
Report: 7994241139
New Hope Care Llc

Food and Beverage Establishment Inspection Report

4-300 Equipment Numbers and Capacities

4-302.13A ***** Priority 2 *****

MN Rule 4626.0710A Provide a readily accessible temperature measuring device for measuring the washing and sanitizing temperatures in manual warewashing operations.

FACILITY DOES NOT HAVE AN APPROVE WAY TO MEASURE DISHWASHER TEMPERATURES. PROVIDED TEST STRIPS AND FACILITY WILL EMAIL PICTURES LATER TODAY.

Comply By: 07/29/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CURRENT CFPM WERE FOUND ON SITE.

Comply By: 07/29/24

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

INSPECTION CONDUCTED IN THE PRESENCE OF HRD STAFF AND FINDINGS SHARED AT THE END OF INSPECTION.

WILL EMAIL SUPPORTING DOCUMENTS AND LINKS TO HRD STAFF AT THE END OF THE DAY.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE

FLOOR IS CERAMIC TILE, CABINETS ARE WOOD WITH HALLOWED ENCLOSED BASES, GRANITE COUNTER TOPS AND POPCORN TEXTURED CEILING. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT ANY TIME THERE IS FOUND TO BE A RISK OF CONTAMINATION OR CONCERN THE PHYSICAL FACILITIES WILL BE REQUIRED TO BE BROUGHT UP TO CODE.

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 7994241139 of 07/29/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/_____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Chukwuemeka Joe Agbagbuo

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981

Type: Full
Date: *07/29/24*
Time: 11:13:09
Report: 7994241139
New Hope Care Llc

Food and Beverage Establishment Inspection Report

Crystal.Elva@state.mn.us

Report #: 7994241139

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health

625 Robert Street North
St Paul

No. of RF/PHI Categories Out	4
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 07/29/24
Time In 11:13:09
Time Out

New Hope Care Llc	**Address** 7949 Orchard Avenue North	**City/State** Brooklyn Park, MN	**Zip Code** 55443	**Telephone** 7632215401
License/Permit # 0039196	**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
Surpervision							
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	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		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:** 07/29/24

Inspector (Signature) Crystal Elva