Electronically Delivered

February 27, 2026

Licensee
Mandas House St. Cloud
2012 7th Avenue South
Saint Cloud, MN 56301

RE: Project Number(s) SL39414016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 29, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39414	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANDAS HOUSE ST CLOUD	2012 7TH AVENUE SOUTH SAINT CLOUD, MN 56301

(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: SL39414016-0 On January 26, 2026, through January 29, 2026, 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 three residents; all of whom were receiving services under the Assisted Living Facility 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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request	0 460		

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. 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 January 27, 2026, at 10:30 a.m., during the	0 460		

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0 460	Continued From page 2 entrance conference, licensed assisted living director (LALD)-C, and housing manager (HM)-A, acknowledged they were familiar with current minimum assisted living requirements. LALD-C and HM-A acknowledged not having a call system for the residents and indicated all residents were independent with mobility. LALD-C stated, "Staff does frequent rounds so residents can contact staff directly." On January 27, 2026, at 12:30 p.m., during a facility tour, the surveyor observed a three-level home with three resident rooms located on the upper floor. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement	0 650		

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0 650	Continued From page 3 needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of one employee (housing manager (HM)-A). 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: HM-A was hired July 9, 2018, to provide direct cares and services to residents. On January 28, 2026, at 7:56 a.m., surveyor observed HM-A administer medications to R2. HM-A's employee records contained an annual review dated 2018, though lacked any annual performance reviews for any other years of employment. On January 29, 20626, at 2 p.m., registered nurse/licensed assisted living director	0 650		

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0 650	Continued From page 4 (RN/LALD)-C stated, "[HM-A] must have forgot to send them, we have them, but maybe he couldn't find them, it's an easy fix so that is fine." The licensee's undated Personnel Records policy, indicated employee records would include documentation of annual performance reviews, which identify areas of improvement and training needs. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
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 5 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 (EP) plan with all the required content. This had the potential to affect all residents receiving services under the assisted living 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 of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: -documentation of being reviewed and any updates made to the plan based on the review annually; - Identify at risk population needs like maintaining independence, communication, transportation, supervision and medical care. - Identify which staff would assume specific roles in another's absence through succession planning and delegation of authority; - Develop and implement EP policies/procedures (P/P) to address the following whether evacuated	0 680		

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0 680	Continued From page 6 or shelter in place for staff/residents: -Food, water, medical supplies, pharmaceutical supplies; -Alternate sources of energy to maintain: -Temperatures to protect resident health/safety; -Safe/sanitary storage of provisions; -Emergency lighting; -Fire detection, extinguishing, alarm systems; and -Sewage and waste disposal; - Develop P/P to shelter in place for residents, staff, and volunteers who remain in the facility; - Develop P/P to address: system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - Develop P/P that must address: use of volunteers, including the process/role for integration; - Conduct exercises to test the EP at least twice per year, including unannounced staff drills using the EP and must include the following: - Participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation 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 that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and - Analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On January 27, 2026, at 9:01 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "We worked with an agency to get the emergency preparedness binder put	0 680		

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0 680	Continued From page 7 together, so we thought we had everything, but we will have to go through and add some things." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all resident's personal health and medical information was kept private. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	0 700		

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0 700	Continued From page 8 On January 27, 2026, from 7:43 a.m. to 7:47 a.m., surveyor observed ULP-A verify resident (R2's) medications. ULP-B then left the electronic medical charting system with information including residents name and medications open on the computer charting system while ULP-B proceeded to another area of the facility to administer medications to R2. The surveyor observed one other resident to be present in the commons area where the computer was left unattended. On January 27, 2026, at 7:59 a.m., registered nurse/licensed assisted living director stated, "That screen is supposed to stay closed; they are not supposed to leave that screen open." On January 28, 2026, from 7:56 a.m. to 8:08 a.m., surveyor observed house manager (HM)-A walk away from the electronic medical record (EMR) charting system with information including residents name and medications open on the computer charting system while HM-A went to another part of the facility. The screen was left open until it timed out on its own, at 8:02 a.m., HM-A went back to the computer and moved the computer mouse to walk the screen up and verify medications. At 8:03 a.m., HM-A again walked away from the computer to attend to other tasks in another area of the facility, leaving the EMR open with medical information displayed. At 8:08 HM-A returned to the computer and closed down the EMR. On January 28, 2026, at 11:15 a.m., HM-A stated, "We are trained that we don't leave [EMR] open and we don't leave it, we should log out when we walk away." The licensee's undated Client Confidentially	0 700		

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0 700	Continued From page 9 policy indicated, "1. Clinical and billing records are kept in a locked area and is not accessible to the public 2. All client's information, including but not limited to personal, financial, and medical data will be keep confidential and related only in the following situations. -Only to authorized persons with an appropriate Release of Information form on file, signed by the client or client representative. -According to law. -To employees or contractors of [Licensee]. -To another home care provider, a health care practitioner or provider, or an inpatient facility that required information to provide services to the client, but only the information that is necessary to provide services. -To representative of the commissioner authorized to survey or investigate home providers. -Client paperwork in the home will be kept in a binder." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
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;	0 910		

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0 910	Continued From page 10 (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 one of one resident (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 the potential to affect a large portion or all the residents). The findings include: R2 was admitted to the licensee and began receiving assisted living services on May 7, 2024. R2's record included a [Licensee] assisted living contract dated August 28, 2025. R2's written contract lacked the following required content: - the contract must include in a conspicuous place and manner on the contract the Health Facility Identification (HFID) number of the facility. On January 28, 2026, at 11:40 a.m., registered nurse/licensed assisted living director (RN/LALD)-C acknowledged all contracts were the same for all residents and stated, "Yes they all are the same."	0 910		

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0 910	Continued From page 11 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910		
01470 SS=D	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 staff member will be providing and	01470		

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01470	Continued From page 12 the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation 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 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 observation, interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services for one of two unlicensed personnel (ULP)-B. 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	01470		

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01470	Continued From page 13 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-B was hired on January 13, 2025, to provide direct care services to residents. On January 27, 2026, at 7:40 a.m., surveyor observer ULP-B administer medications to R2. ULP-B's employee records lacked evidence of orientation to assisted living regulations (144G.63, Sub. 2) effective August 1, 2021, for the following: -Handling emergencies and using emergency services; -Reporting maltreatment of vulnerable adults or minors; and -Principles of person-centered planning/service delivery. On January 27, 2026, at 11:47 a.m., registered nurse/licensed assisted living director (RN/LALD)-C acknowledged the missing training and stated, "Well, I am not sure why it was not [in his training record], but I will assign it for his renewal." The licensee's undated Staff Orientation & Education policy indicated, "Orientation is provided by the RN or delegate. All clinical topics will be addressed by the RN or other appropriately licensed health care professional." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	01470		

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01470	Continued From page 14 (21) days	01470		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation 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 staff member until the training requirement is complete. Direct-care staff	01530		

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01530	Continued From page 15 must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the license failed to complete two hours of initial training on mental illness and de-escalation for employees hired prior to July 1, 2025, for one of one unlicensed personnel (ULP)-B. 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: ULP-B was hired on January 13, 2025, to provide direct care services to residents. On January 27, 2026, at 7:40 a.m., surveyor observer ULP-B administer medications to R2. ULP-B's employee record lacked evidence the employee received the required initial two hours of mental illness/de-escalation training. On January 27, 2026, at 11:38 a.m., registered nurse/licensed assisted living director (RN/LALD)-C was asked if any staff have had the	01530		

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01530	Continued From page 16 required initial two hours of mental illness/de-escalation training, and RN/LALD-C stated, "I don't think so because it is something new and we didn't get a notification that it was added [to the requirements]." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days.	01620		

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01620	Continued From page 17 (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an ongoing resident reassessment to include all areas required on the uniform assessment tool for one of one resident (R2) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	01620		

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01620	Continued From page 18 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee and began receiving assisted living services on May 7, 2024. R2 had diagnoses to include schizophrenia, obesity, anxiety, bipolar disorder, borderline personality disorder, and major depression. R2's Service Plan dated August 28, 2025, indicated R2 received services for medication management, grooming assistance, dressing assistance, laundry, daily blood pressure monitoring, housekeeping, and behavior management. R2's 90-day reassessments titled Nurse Reassessment visit dated November 22, 2025, lacked the following areas required on the uniform assessment tool: -the resident's personal lifestyle preferences; -sleep schedule; -spiritual and cultural preferences; -advance health care directives and end-of-life preferences, including whether a person has or wants to seek a "do not resuscitate" order and "do not attempt resuscitation order" or "physician/provider orders for life-sustaining treatment" order; -instrumental activities of daily living; -allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities are life threatening; -a review of medical, dental, and emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a postacute care facility.	01620		

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01620	Continued From page 19 On January 28, 2026, at 11:27 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "There are more pages to the assessment but I can't find them or get them to print, but I am telling you we do the full assessment I just can't get it for you from our system. I am calling them to see if they can find them. We use the Therap system and [the residents] all have the same assessments" On January 29, 2026, at 2:00 p.m., RN/LALD-C stated, "I called [the electronic charting company] and they are not able to get the rest of the assessments for any of the residents. So, I re-did the assessment today and sent it to you. Can you look it over and let me know what is still missing for educational purposes." The licensee's undated Assessment-Comprehensive policy, indicated the licensee would use conduct a comprehensive assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01820 SS=F	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:	01820		

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01820	Continued From page 20 Based on interview and record review, the licensee failed to ensure written or electronically recorded prescriptions were obtained 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 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: R2 was admitted to the licensee and began receiving assisted living services on May 7, 2024. R2 had diagnoses to include schizophrenia, obesity, anxiety, bipolar disorder, borderline personality disorder, and major depression. R2's Service Plan dated August 28, 2025, indicated R2 received services for medication management, grooming assistance, dressing assistance, laundry, daily blood pressure monitoring, housekeeping, and behavior management. R2's Medication Administration Record (MAR) dated January 1, 2026, through January 31, 2026, listed the medications, times to administer, and staff initials to indicate the medications had been administered. The MAR indicated that R2 received clozapine 100 milligram (mg) twice daily (BID), Eliquis 5 mg BID, furosemide 40 mg once daily, levothyroxine 75 micrograms (mcg) once daily, propranolol 20 mg Three times daily (TID),	01820		

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01820	Continued From page 21 risperidone 4 mg BID, laxative 8.6-50 mg once daily, and vitamin D3 2000 units (U) once daily. R2's record lacked signed orders for clozapine 100 milligram (mg) twice daily (BID), Eliquis 5 mg BID, furosemide 40 mg once daily, levothyroxine 75 micrograms (mcg) once daily, propranolol 20 mg Three times daily (TID), risperidone 4 mg BID, laxative 8.6-50 mg once daily, and vitamin D3 2000 units (U) once daily. On January 27, 2026, at 11:19 a.m., registered nurse/licensed assisted living director (RN/LALD)-C stated, "Usually, we get a copy of the scripts from the pharmacy, but I am looking, and I am not seeing all of them, so I called pharmacy, and they are going to send them to me today." Surveyor asked if the other two residents would have signed orders and RN/LALD-C stated, "I don't think I have them so let's just move on." The licensee's undated Access to Record policy, indicated the licensee would maintain a resident's health record for each resident and records would be stored in a secured area of the home care office, and the resident records would include prescriptions signed by the supervising physician. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments	01880		

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01880	Continued From page 22 according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted only authorized personnel to have access for 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 January 27, 2026, at 11:00 a.m., registered nurse/licensed assisted living director (RN/LALD)-C went to the medication closet, unlocked it and opened it, then RN/LALD-C closed the medication closet and leaving the key in the closet door RN/LALD-C walked away to another part of the facility. At 11:04 a.m., RN/LALD-C came back to the medication closet, locked the closet and retrieved the key. On January 28, 2026, at 8:03 a.m., house manager (HM)-A unlocked the medication closet and retrieved medications for R2 and then went to a different area of the facility while leaving medication closet open and unlocked. At 8:08 a.m., HM-A returned to the medication closet and closed and locked the medication closet.	01880		

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01880	Continued From page 23 On January 28, 2026, at 11:14 a.m. HM-A indicated they have training on keeping medications secure and stated, "We talk about the med room and protocols about the med room, it needs to be locked all the time, so if you are not in there its locked and you keep the key on you and don't leave it open." On January 28, 2026, at 12:05 p.m., RN/LALD-C stated, "The door must be locked at all times, and the key must be on them." The Licensee's undated Storage/Control of Medications policy, indicated medications would be securely locked, in accordance with the manufacture's guidelines, and access would be prohibited to authorized personnel only. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
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	01910		

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01910	Continued From page 24 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 by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition for one of three discharged 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 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 was admitted to the licensee and began receiving services on July 12, 2023. R1's discharged on December 20, 2024. R1's Service Agreement/Plan dated July 12, 2023, included medication administration.	01910		

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01910	Continued From page 25 R1's record included an unsigned, undated discharge summary that read, "Disposition of Medications: All medication and equipment given to client team upon discharged." R1's record lacked a medication disposition. On January 27, 2026, at 8:24 a.m., registered nurse/licensed assisted living director (RN/LALD)-C acknowledged they did not have the medication disposition for R1, and stated, "We took his chart apart and I wasn't able to get into it this morning, so I will see if we got a copy of it. We discharged him from the system and the only thing I was able to find was an old service plan, and I can show you that, we sent his medications with him, but he did not want to sign. He was upset that day." The licensee's undated Disposition/Disposal of Medications policy, indicated the licensee would document the following information in the resident's file upon disposition: a. Name, strength, and prescription number of medications, as applicable b. Quantity c. Method of disposition or to whom the medications were given d. Date of disposition e. Name(s)/signature(s) of staff involved in disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANDAS HOUSE ST CLOUD	2012 7TH AVENUE SOUTH SAINT CLOUD, MN 56301

(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
01940	Continued From page 26 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content and failed to include all treatments or therapies ordered for one of one resident (R2).	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39414	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANDAS HOUSE ST CLOUD	2012 7TH AVENUE SOUTH SAINT CLOUD, MN 56301

(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
01940	Continued From page 27 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: R2 was admitted to the licensee and began receiving assisted living services on May 7, 2024. R2 had diagnoses to include schizophrenia, obesity, anxiety, bipolar disorder, borderline personality disorder, and major depression. R2's Service Plan dated August 28, 2025, indicated R2 received services for medication management, grooming assistance, dressing assistance, laundry, daily blood pressure monitoring, housekeeping, and behavior management. R2's Medication Administration Record (MAR, dated January 1, 2026, through January 31, 2026, indicated R2 had instructions for blood pressure checks once daily in the morning. R2's MAR form did not indicate any instructions for blood pressure parameters, what staff should do for any blood pressure issues, or any signs and symptoms to update the nurse. On January 28, 2026, at 8:02 a.m., surveyor observed house manager (HM)-A obtained R2's blood pressure prior to administering R2's medications. R2's unsigned and undated comprehensive	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39414	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANDAS HOUSE ST CLOUD	2012 7TH AVENUE SOUTH SAINT CLOUD, MN 56301

(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
01940	Continued From page 28 assessment lacked an evaluation of treatment and therapies to include: - resident specific instructions related to the treatments/therapy administration; and - process for notifying an RN or appropriate licensed health professional when an issue or concern arises. On January 28, 2026, at 11:23 a.m., registered nurse/ licensed assisted living director (RN/LALD)-C stated, "There is supposed to be a protocol in the communication binder. I am unsure why it is not there; I will have to look into that; it should be there." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee's contract used language which limited the rights of all residents residing within the facility. 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	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39414	A. BUILDING: _____ B. WING _____	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANDAS HOUSE ST CLOUD	2012 7TH AVENUE SOUTH SAINT CLOUD, MN 56301

(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
02290	Continued From page 29 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 January 27, 2026, at 8:02 a.m., the registered nurse/licensed assisted living director (RN/LALD)-C provided a blank {Licensee] Assisted Living Contract that read, "The resident has the right to choose the resident's visitors and times of visits and restrictions will be communicated by [Licensee] as allowed under Minn Stat 144G.50. a. Guests are permitted in the residence, no overnight guests are allowed for the safety of other residents and staff as allowed under Minn Stat 144G.50." On January 28, 2026, at 11:40 a.m., RN/LALD-C acknowledged all contracts were the same for all residents and stated, "Yes they all are the same, and it is just as it says, no overnight guests, the population we serve, they are unpredictable, so we have to restrict who can be around and how long they can be around, because we have delicate residents." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02290		

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

MandaÆs House
2012 7th Ave South
St Cloud, MN 56301
Stearns County
Parcel:

Phone:

License Info

License: 0042050

Risk:
License: -1
Expires on: 12/31/2023
CFPM: Daniel Patrick Schaeppi
CFPM #: 10500; Exp: 6/12/2028

Inspection Info

Report Number: F1046261026
Inspection Type: Full - Single
Date: 1/28/2026 Time: 11:15:29 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

Food & Beverage General Comment

FIRE LAST TAGGED IN JANUARY 2025. ENSURE FIRE TAG IS UPDATED BY END OF JANUARY 2026.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the St Cloud District Office inspection report number F1046261026 from 1/28/2026

Establishment Representative

Nicole Larrison,
Public Health Sanitarian 1
320-640-3534
nicole.larrison@state.mn.us

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Establishment Info

MandaÆs House
St Cloud
County/Group: Stearns County

Inspection Info

Report Number: F1046261026
Inspection Type: Full
Date: 1/28/2026
Time: 11:15:29 AM

Food Temperature: Product/Item/Unit: COLESLAW**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 43 Degrees F.
Comment: WAS RECENTLY OUT FOR LUNCH PREP
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SLICED HAM**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Establishment Info

MandaÆs House
St Cloud
County/Group: Stearns County

Inspection Info

Report Number: F1046261026
Inspection Type: Full
Date: 1/28/2026
Time: 11:15:29 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 160.0 Degrees F.
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1046261026

Food Establishment Inspection Report

St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

No. of Risk Factor/Intervention/Violations	0	Date: 1/28/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:15:29 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
MandaÆs House	2012 7th Ave South	St Cloud, MN	56301	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
0042050		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

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

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions 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" or OUT 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	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
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 and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature)

Follow-up: Follow-up Date: