DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 13, 2022

Administrator
Heritage Place
303 Troendle Street Southwest
Mapleton, MN 56065

RE: Project Number(s) SL28389015

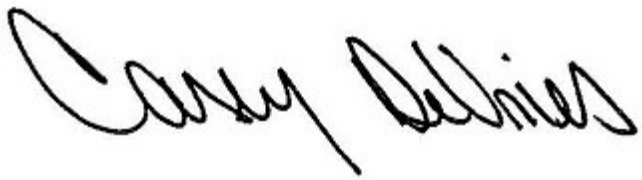
Dear Administrator:

On September 7, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the June 29, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

PMB

Electronically Delivered

July 27, 2022

Administrator
Heritage Place
303 Troendle Street Southwest
Mapleton, MN 56065

RE: Project Number(s) SL28389015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 29, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes 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. The Department of Health 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 (a)(5)(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 evaluation:

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000

The total amount you are assessed is $3,000. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:	Free from Maltreatment reconsideration requests should be addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28389	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PLACE	303 TROENDLE STREET SW MAPLETON, MN 56065

(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 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: SL28389015 On June 27, 2022, through June 29, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 17 residents; 10 of which were receiving services under the provider's Assisted Living license. On June 29, 2022, at 8:50 a.m. the immediacy of correction order 2310 was removed; however, non-compliance remains at a level three, widespread (I).	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-A was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On June 27, 2022, at 12:02 p.m. the Minnesota Board of Executives for Long-Term Services and Support (BELTSS) website indicated LALD-A currently held a LALD license effective through October 31, 2022; however, LALD-A's license lacked an organization listed as the Director of Record for the licensee. On June 27, 2022, at 3:30 p.m. LALD-A acknowledged they were not listed as Director of Record with BELTSS and indicated being aware of the requirement, but had overlooked it. No further information was provided.	0 110		

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0 110	Continued From page 2 TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure that one or more	0 470		

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0 470	Continued From page 3 persons were available 24 hours per day, seven days per week, who were responsible for responding to the requests of residents, were located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time. In addition, the licensee failed to develop and implement a staffing plan for determining its staffing level that included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in 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 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: The licensee held an assisted living facility license with a bed capacity of 40 residents; with a current census of 17 residents. During the entrance conference on June 27, 2022, at 9:45 a.m. registered nurse (RN)-B stated beside nursing coverage during the day Monday through Friday, there was one unlicensed personnel (ULP) from 6:00 a.m. to 2:30 p.m. and one ULP from 2:30 p.m. to 9:00 p.m. each day. RN-B and licensed assisted living director (LALD)-A stated between the hours of 9:00 p.m. to 6:00 a.m. staff from the attached nursing home responded. On June 27, 2022, at 2:15 p.m. LALD-A stated	0 470		

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0 470	Continued From page 4 the licensee did not have a waiver for using nursing home staff between the hours of 9:00 p.m. and 6:00 a.m. and if a pull cord or pendant was utilized by a resident during this time, a staff member from the attached nursing home would come to assist. LALD-A further stated the call light and fire alarm systems were integrated with the attached nursing home and nursing home staff were trained on the emergency preparedness to assist the licensee's residents. On June 29, 2022, at 9:56 a.m. human resource director (HR)-D stated nursing home staff that cover between the hours of 9:00 p.m. to 6:00 a.m. were not orientated to assisted living standards. HR-D indicated all staff are hired under the company umbrella, but nursing home staff would not be trained to assisted living standards specifically. The licensee's Staffing Plan undated, identified one resident assistant from 6:00 a.m. to 2:30 p.m., one resident assistant from 2:30 p.m. to 9:00 p.m., one housekeeper for 40 hours a pay period, one RN/licensed practical nurse (LPN) 24 hours a day on call, director of nursing/assistant director of nursing (DON/ADON) or charge nurse at the nursing home. If residents become high acuity, add one resident assistant from 9:00 a.m. to 5:00 p.m. A separate document titled Licensee's Staffing Plan undated, noted 24-hour staff is provided in conjunction with staff from nursing home answering emergency requests from 9:00 p.m. to 6:00 a.m. daily. A nurse is available 24/7 to the residents and the staff if a need arises. Essential services (required for medical or safety reason) are available to residents from 6:00 a.m. until 9:00 p.m. each day.	0 470		

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0 470	Continued From page 5 The licensee's Call Lights and Falls After Hours policy/procedure undated, included: When answering a light that involves helping someone: - Sign your initials so that person is charged for the visit; - Write a progress note regarding the incident; - Send an email to groupallusers and mchnurses so that everyone is aware of the incident. If answering the light involves a fall: - Assist person off the floor, if able; - If the person is requiring more than assist of two to get off the floor, call 911; - Obtain a set of vital signs and fill out the initial fall report; - Write a progress note detailing the incident; - Send an email to groupallusers and mchnurses. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional 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.	0 550		

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0 550	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure as well as the required information related to the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. 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 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: On June 27, 2022, at 10:20 a.m. during the facility tour, the surveyor noted a bulletin board by the resident mailboxes that contained the month's menu and activity schedule, and a bulletin board in the resident laundry room area; however, there was no evidence of the grievance procedure or contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. On June 27, 2022, at 10:45 a.m. licensed assisted living director (LALD)-A confirmed the content noted above was not posted as required	0 550		

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0 550	Continued From page 7 and was not aware it was missing. The licensee's Procedure for Postings policy undated, identified postings required: grievance procedure (conspicuous location). 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: 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 911 emergency number as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 640		

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0 640	Continued From page 8 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: On June 27, 2022, at 10:20 a.m. during the facility tour, the surveyor noted a bulletin board by the resident mailboxes that contained the month's menu and activity schedule, and a bulletin board in the resident laundry room area; however, there was no evidence of posting the MAARC hotline in the common areas of the facility or 911 phone number. Licensed assisted living director (LALD)-A confirmed this finding and indicated she was not aware it had been missing. The licensee's Procedure for Postings policy undated, identified postings required: 911 emergency number in common areas and by phones provided by the facility and Minnesota Adult Abuse Reporting Center information and reporting number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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0 680	Continued From page 9 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 tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post emergency exit diagrams in the required areas on each floor. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that	0 680		

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0 680	Continued From page 10 has affected or has the potential to affect a large portion or all of the residents). The findings include: During a tour of the facility on June 27, 2022, at 10:20 a.m., the surveyor observed no emergency exit diagrams in the hallways of either first or second floor of the licensee's building. On June 29, 2022, at 12:57 p.m. director of maintenance (DM)-F confirmed the licensee lacked exit diagrams on each floor as required. The licensee's Procedure for Postings policy undated, identified postings required: emergency exit diagrams on each floor. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but	0 780		

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	28389	A. BUILDING: _____ B. WING _____	06/29/2022

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0 780	Continued From page 11 not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain smoke alarms in the facility as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On 06/28/2022 between 11:30 AM to 01:30 PM, survey staff observed that smoke alarms located in bedrooms and throughout the facility could not be assessed for month/year of install or manufacture date. (DM)-F verbally confirmed survey staff observations.	0 780		

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0 780	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
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. (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	0 810		

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0 810	Continued From page 13 drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain their fire safety and evacuation plan, provide the required fire safety training and evacuation plans for residents and staff, and conduct and document drills. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the potential to affect a large portion or all residents). Findings include: On 06/28/2022 between 11:30 AM to 01:30 PM, survey review of documentation showed the following: 1. The Fire Safety and Evacuation Plan presented for review was template format and not specific to the facility in showing local 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 2. No documentation was provided to confirm that the staff of the facility had received initial fire safety and evacuation training at the time of hire, as well as ongoing required twice per year	0 810		

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0 810	Continued From page 14 thereafter. 3. Fire safety and evacuation plans documentation location points in the facility were yet to be determined 4. No documentation was provided to confirm that residents who are capable of assisting in their own evacuation were being trained on proper actions at least once a year 5. No records were provided to confirm that evacuation drills are being conducted twice per year per shift with at least one drill every other month (DM)-F verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=E	144G.60 Subdivision 1 Background studies required (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	01290		

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01290	Continued From page 15 liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for staff assisting in cares from the attached nursing home of licensee and for one of two employees (unlicensed personnel (ULP)-C) with records 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-C was hired on August 22, 2013, and started providing direct care and services to the licensee's residents under the assisted living license on August 1, 2021. On June 28, 2022, at 7:35 a.m. ULP-C was observed to administer medications to R1. ULP-C's employee record contained a background study dated August 26, 2013, for a separate location operated by the licensee's owner. ULP-C's employee record lacked evidence the licensee affiliated a background study for their license.	01290		

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01290	Continued From page 16 On June 29, 2022, at 9:00 a.m. human resource director (HR)-D confirmed staff assisting with cares between the hours of 9:00 p.m. and 6:00 a.m. from the attached nursing home did not have background studies that were affiliated, but rather under a different license for the nursing home. HR-D further confirmed ULP-C's background study was submitted under a different license and had not been affiliated. HR-D stated she had only affiliated the managers. The licensee's Handbook undated, included: The Minnesota Department of Health requires criminal background studies to be completed on all employees who provide direct care to our residents. Only employees who successfully pass the study are allowed to work for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=E	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	01470		

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01470	Continued From page 17 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 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	01470		

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01470	Continued From page 18 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 staff assisting in cares from the attached nursing home of licensee and one of two employees (registered nurse (RN)-B) received orientation to assisted living facility licensing requirements and regulations before providing 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, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: RN-B was hired on June 13, 2012, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-B's employee record lacked evidence of receiving orientation to assisted living to include the following required content: - an overview of this chapter; - an introduction and review of the facility's policies and procedures related to the provision of	01470		

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01470	Continued From page 19	01470		

assisted living services by the individual staff person;
- handling of emergencies and use of emergency services;
- compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);
- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;
- handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;
- 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 assisted living services the employee will be providing and the facility's category of licensure.

On June 29, 2022, at 9:56 a.m. human resource director (HR)-D indicated nursing home staff that covered between the hours of 9:00 p.m. to 6:00 a.m. were not trained on assisted living orientation, because they are not assigned assisted living training when they are nursing home employees. HR-D further stated RN-B had been assigned the above required training, but had not completed it. HR-D stated normally audits were completed to ensure required trainings were done by staff, but that person had been out on medical leave.

On June 29, 2022, at 1:00 a.m. RN-B verified her

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01470	Continued From page 20 record lacked the above assigned required content and was unable to find additional certificates of training that would meet the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01470		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced	01620		

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01620	Continued From page 21 by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment for one of one resident (R1) with records 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 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's record lacked evidence the RN conducted a reassessment no more than 90 calendar days from the date of the last assessment. R1's Service Care Plan dated October 19, 2021, indicated R1 received services that included thromboembolism-deterrent (TED) hose (support stockings to prevent blood clots) application and removal, ambulation in hallway, and medication administration. R1's last three assessments were requested. Client Monitoring Visit Note dated October 22, 2021, January 21, 2022, and April 21, 2022, were provided. The January 21, 2022, assessment was 91 days from the last date of the assessment, exceeding 90 calendar days. On June 29, 2022, at 11:20 a.m. RN-B stated she had been going by calendar dates when scheduling the reassessments and did not count	01620		

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01620	Continued From page 22 out 90 days. RN-B indicated she did not consider that some months have more or less days than others. RN-B further verified the assessment was greater than 90 days from the previous reassessment. The licensee's Initial and On-Going Nursing Assessment of Clients policy dated January 2014, indicated the RN would re-assess each client and update the service plan based on the client's needs and at a frequency not to exceed 90 days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled correctly for one of two residents (R4) with medication administration observation. 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	01890		

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01890	Continued From page 23	01890		

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:

R4's physician orders dated June 8, 2022, included an order to decrease potassium chloride (potassium supplement) extended release (ER) 20 milliequivalents (mEq) one (1) tablet by mouth twice daily, to once daily.

R4's medication administration record (MAR) dated June 2022, included the same order for potassium chloride ER 20 mEq one time a day for potassium supplement.

On June 28, 2022, at 7:59 a.m. unlicensed personnel (ULP)-C prepared morning medications to be administered to R4. ULP-C removed the medication card from the medication cart, and compared it to the MAR, then punched a potassium chloride ER 20 mEq one tablet into the medication cup. The surveyor examined the medication card and noted the label did not match the order. The label had R4's name on it, but it read "potassium chloride 20 mEq capsule ER take one table by mouth twice daily." ULP-C stated there had been an order change on June 9, 2022, and was able to show surveyor in computer system where order changed from twice daily dosing to once daily dosing. ULP-C further stated changes were emailed to staff, but did not know why the medication label did not match the order.

On June 29, 2022, at 11:14 a.m. registered nurse (RN)-B stated medication cards could not be sent

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01890	Continued From page 24 back to the pharmacy but indicated there should be an alert on the medication card of the dose change. RN-B confirmed all medication labels need to match the prescriber order. The licensee's Renewal of Medication, Treatment or Therapy Prescriptions and Orders policy dated July 27, 2021, identified when a renewed or revised order has been received, the RN or licensed health profession will place the signed renewal order in the client's permanent record and will make any necessary updates to the service plan, care plan, medication record/MAR or other documents. No further information provided. TIME PERIOD FOR CORRECTION: seven (7) days.	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name,	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28389	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PLACE	303 TROENDLE STREET SW MAPLETON, MN 56065

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 25 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 document in the resident's record the disposition of the medication including the medication's prescription number as applicable, for one of one discharged resident (R2) with record review. 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: During the entrance conference on June 27, 2022, at 9:45 a.m. registered nurse (RN)-B provided the discharge resident roster. The discharge roster indicated R2 discharged on January 13, 2022, to another facility. R2's service plan dated May 6, 2016, indicated services included medication administration. An untitled typed document dated January 4, 2022, included medications that had been sent to nursing home where R2 had transferred to. The document identified the medication name, strength, quantity, date, method of disposition, and signature of nurse. The document did not	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28389	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PLACE	303 TROENDLE STREET SW MAPLETON, MN 56065

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 26 include the prescription number for any of the identified medications including: amlodipine (blood pressure), Flonase nasal spray (allergies), gabapentin (anticonvulsant), glimepiride (diabetes), multivitamin (supplement), oxybutynin (bladder), vitamin D3 (supplement), cholestyramine powder (cholesterol), metoprolol tartrate (blood pressure), Systane solution (dry eyes), torsemide (fluid), Coumadin (blood thinner). On June 28, 2022, at 12:48 p.m. RN-B verified the prescription numbers of the medications were not identified on the disposition of medications. RN-B stated the licensee had a form that included the required components for the disposition, but had not utilized the form for this transfer and should have. The licensee's Content of Client's Medication Records policy dated July 27, 2021, included: documentation of the disposition of any medications that our agency is managing when the medications are discontinued, expired, or when the client's medication management services are terminated. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28389	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PLACE	303 TROENDLE STREET SW MAPLETON, MN 56065

(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
02310	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical or nursing standards for one of one resident (R3) with a side rail. This resulted in an immediate correction order on June 28, 2022, at 2:20 p.m. 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 potential to affect a large portion or all of the residents). The findings include: R3's diagnosis included orthopedic aftercare, epilepsy and personality disorder. On June 28, 2022, at 12:19 p.m. the surveyor observed R3 lying in bed with a sling on his left arm. An upside down "U" shaped side rail with a black vinyl pouch covering was located on the right side near the head of R3's bed. The grab bar was secured to the bed frame. R3 stated he used the grab bar for transfers in and out of bed. R3 then proceeded to sit upright from a lying position utilizing the grab bar to assist with bed mobility. R3 further stated a home care therapist had ordered and installed the grab bar to his bed to assist in bed mobility following his recent left rotator cuff surgery.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28389	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PLACE	303 TROENDLE STREET SW MAPLETON, MN 56065

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02310	Continued From page 28 R3's Service Care Plan dated June 10, 2022, indicated R3 received services which included medication administration, hygiene/grooming assistance, bathing, laundry, and housekeeping. R3's record identified R3 had been given a copy of the side rail policy and explained the risk/benefits of using a side rail; however, R3's record lacked any assessment of the side rail. On June 28, 2022, at 12:48 p.m. registered nurse (RN)-B stated she talked to R3 about the risk vs. benefits of the side rail, and watched him use it, but RN-B did not document any assessment stating, "I know, not documented not done." RN-B stated she had not been completing assessments for any residents that had side rails. RN-B added there were no manufacturer instructions for the side rail, further confirming she would have no way of knowing if the side rail had been recalled, installed correctly, or of any limitations or safety considerations with it's use. The licensee's Assessing the Safety of Side Rails policy dated January 2016, noted the RN would assess and evaluate what the resident's needs are and assess to determine if the resident can safely utilize the side rail/equipment. If the RN determines that the resident is not able to safely use a side rail, or that the side rail does not meet the Food and Drug Administration (FDA) or most current safety guidelines, the RN will recommend that the side rail be removed and will document this recommendation, will document to whom the education was directed and will document the person who was given the recommendation to remove the side rail. No further information was provided.	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28389	A. BUILDING: _____ B. WING _____	06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PLACE	303 TROENDLE STREET SW MAPLETON, MN 56065

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02310	Continued From page 29 TIME PERIOD FOR CORRECTION: Immediate On June 29, 2022, at 8:50 a.m. the immediacy of correction order 2310 was removed based on observations by surveyor and record reviews by evaluation supervisor; however, non-compliance remains at a scope and level of I. TIME PERIOD FOR CORRECTION: Two (2) Days	02310		

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *06/28/22*
Time: 11:05:07
Report: 1020221071

Food and Beverage Establishment Inspection Report

Location:
Heritage Place
303 Troendle Street Sw
Mapleton, MN56065
Blue Earth County, 07

Establishment Info:
ID #: 0037968
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5075243315
ID #:

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - UPRIGHT FREEZER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: DRESSING - UPRIGHT COOLER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 176 Degrees Fahrenheit - Location: BROCCOLI - STEAM TABLE
Violation Issued: No

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

GENERAL COMMENTS:

DISCUSSED EMPLOYEE ILLNESS POLICIES AND PROCEDURES. EMPLOYEE ILLNESS IS HANDLED BY INFECTION CONTROL NURSE ON-SITE.

FOOD IS BROUGHT OVER ON CARTS FROM THE KITCHEN IN THE NURSING HOME. TEMPS ARE TAKEN WHEN ARRIVING TO THE ASSISTED LIVING KITCHEN AND PLACED IN A STEAM TABLE. ANY LEFT OVER FOOD IS DISCARDED.

Food and Beverage Establishment Inspection Report

TEMPERATURE LOGS OF FOOD TEMPS AND COLD-HOLDING UNITS ARE TAKEN DAILY.

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 1020221071 of 06/28/22.

Certified Food Protection Manager: Victoria L. Kirksey

Certification Number: FM74899 Expires: 09/09/23

Inspection report reviewed with person in charge and emailed.

Signed: Report emailed
Establishment Representative

Signed: Ashley B
651-201-4500

Report #: 1020221071

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	0	Date	06/28/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:05:07
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Heritage Place	303 Troendle Street Sw	Mapleton, MN	56065	5075243315

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0037968		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) Report emailed **Date:** 07/05/22

Inspector (Signature)