



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 23, 2023

Licensee
Senior Living LLC
8478-8480 Adair Avenue North
Brooklyn Park, MN 55443-2049

RE: Project Number(s) SL37823015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial evaluation on March 3, 2023, for the purpose 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.

STATE LICENSING ORDERS

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 Home Care 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 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 and enforcement actions based on the level and scope of the violations; however, no immediate fines are assessed for this evaluation of your facility.

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 residents/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.

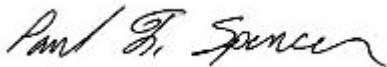
Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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,



Paul Spencer, Supervisor
State Rapid Response Team
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Email: paul.spencer@state.mn.us
Telephone: 651-587-4460 Fax: 651-215-6894

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37823	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 03/03/2023
NAME OF PROVIDER OR SUPPLIER SENIOR LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8478-8480 ADAIR AVENUE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDERS 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: #SL37823015 On February 27, 2023, through February 28, 2023, 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 was one resident receiving services under the provider's Provisional Assisted Living license.	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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 470	Continued From page 1 (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 develop or implement a staffing plan to determine its staffing level. This had the potential to affect 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, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living license, effective August 1, 2021. The licensee was licensed for a resident capacity of 5 residents and had a current census of 1 resident. During the entrance conference on February 28, 2023, at 10:30 a.m., registered nurse (RN)-B explained how the licensee staffed its building. RN-B also said the licensee had not developed a staffing plan. The licensee's Staffing policy, dated August 1, 2021, indicated the clinical nurse supervisor would prepare and implement a twenty-four (24) hour daily staffing plan that would ensure adequate staffing to meet resident needs at all times. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by:	0 480		

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0 480	Continued From page 3 Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated March 1, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide	0 660		

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0 660	Continued From page 4 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) were completed within the required timeframe and documented for two of four, (registered nurse (RN)-C and unlicensed person (ULP)-E) with employee records reviewed. This had the potential to effect 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: During an interview on February 28, 2023, at 9:20 a.m., during the entrance conference, registered nurse (RN)-B confirmed knowledge of assisted living rules and regulations. On February 28, 2023, at 10:24 a.m., employee files were requested.	0 660		

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0 660	Continued From page 5 RN-B was hired on November 8, 2022. RN-B's TB screening was not completed upon hired. Unlicensed personnel (ULP)-C was hired on October 1st, 2021. ULP-C's TB screening was not completed upon hired. ULP-D was hired on November 17, 2021. ULP-D's TB screening was not completed upon hired. Licensee policy titled Tuberculosis Prevention and Control, undated, indicated the facility will, at no cost to the employee, offer Tb Mantoux skin test or a blood test at the time of employment and as indicated in situations of Tb exposure. Employees who can show evidence of a negative Mantoux within three (3) months prior to hire date may use that test as step one of two step test at the time of employment. Employees who have documentation of a negative blood test or a negative chest x-ray within three (3) months of employment do not need to have it repeated. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an	0 680		

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0 680	Continued From page 6 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure it completed a written emergency disaster plan with all required content and post the emergency plan prominently. This had the potential to affect all current residents receiving services under the assisted living license, staff, and visitors to 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, 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:	0 680		

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0 680	Continued From page 7 The facility was licensed as an assisted living facility. On February 28, 2023, at 9:20 a.m., during the entrance conference, registered nurse (RN)-B confirmed knowledge of assisted living rules and regulations. On February 28, 2023, at 9:45 a.m., the licensee's emergency preparedness (EP) Plan was reviewed. A review of the documents found the following required content missing from the plan. - Coordination or contracts with other facilities in an event of evacuation, major incident, or cessation of operations to maintain the continuity of services to residents. - EP binder was not labeled or readily identifiable for staff, visitors, or emergency personnel. - Identify which staff would assume specific roles in another 's absence through succession planning and delegation of authority. - On-duty staff and sheltered residents that need to be relocated, name and location of the receiving facility or other location was not identified. - Responsibilities of staff members and what role they would conduct in the event of an emergency. - No evidence that emergency drills have been conducted. On February 28, 2023, at 12:15 p.m., RN-B verified the EP plan was missing the required content. An emergency preparedness plan policy was not provided.	0 680		

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0 680	Continued From page 8	0 680		
0 780 SS=F	TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 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 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 provide smoke alarms that are interconnected so that actuation of one alarm causes all alarms in the dwelling unit to actuate.	0 780		

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0 780	Continued From page 9 This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On facility the tour with the Manager (UPL)-C on March 1, 2023, at approximately 10:00 a.m., it was observed that upon testing, the smoke alarms in the facility were not interconnected so that the actuation of one smoke alarm would cause all other alarms in the facility to actuate. It was also observed that resident bedroom #2 on the upper level and resident bedroom #2 on the lower level were equipped with a smoke alarm but did not work when it was tested. These deficient conditions were visually verified by UPL-C accompanying the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790		

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0 790	Continued From page 10 (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide adequately rated portable fire extinguishers as required for the facility and failed to maintain fire extinguishers in accordance with MN State Fire Code as required by MN Statute 144G.45 Subd.2 (a)(2). This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On March 1, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Manager (UPL)-C. It was observed that each of the fire extinguishers provided was 1-A:10-BC rated and did not have at least one 2-A:10-B:C rated fire extinguisher as required by MN Statute 144G.45. It was observed that the fire extinguisher did not have an annual maintenance tag showing that it	0 790		

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0 790	Continued From page 11 had been inspected as required by MN State Fire Code and lacked records to show the required monthly visual inspections were performed for portable fire extinguishers. UPL-C visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the ability to affect a limited number of staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 800		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER SENIOR LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 8478-8480 ADAIR AVENUE NORTH BROOKLYN PARK, MN 55443		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 12 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On March 1, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Manager (UPL)-C. During the facility tour, survey staff observed the following items: In the lower-level Bathroom, it was observed the following items: - It was observed that the room had considerable damage to the sheetrock ceiling and sheetrock above the bathtub, with - evidence of water damage. - It was observed that the return air grille was rusted badly with evidence of moisture. - It was observed that the bathtub was clogged and did not drain water. - It was observed that the cabinet was broken, and the cabinet door was missing. In upper-level bedroom #1, it was observed that the window screen was missing, and there was a hole in the door. In upper-level bedroom #2, it was observed that there were large red and brown stains on the carpet, and it was observed that the return air grille was covered with thick dust. In upper-level bedroom #3, it was observed that the return air grille was covered with thick dust and the door hardware was rusted with evidence of moisture in the area. On the deck from the kitchen, it was observed	0 800		

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0 800	Continued From page 13 that the burnt used cigarettes were being disposed of without a proper disposal container creating a possible fire hazard. In the lower-level closet next to the stair, it was observed that the ceiling lighting fixture was broken and hanging loose from the ceiling. UPL-C visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (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	0 810		

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0 810	Continued From page 14 proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review, observation, and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements; failed to provide required employee training on fire safety and evacuation; failed to provide training on fire safety and evacuation to residents capable of self-evacuation; failed to show fire protection procedures necessary for residents, and procedures for movement, evacuation, or relocation including identification of unique or unusual resident needs, and failed to complete required employee evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include:	0 810		

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0 810	Continued From page 15 An interview and record review of the available documentation were conducted on March 1, 2023, at approximately 10:00 a.m., with the Manager (UPL)-C on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During the interview, UPL-C verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation in the procedures for resident movement, evacuation, or relocation during a fire or similar emergency. During the interview, UPL-C verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review indicated that employees did not receive training twice per year after initial hire. During the interview, UPL-C stated that the licensee provided annual training to employees on 2/10/23, but not twice per year after the initial hire on the fire safety and evacuation plan, as required by statute. A policy was requested on employee training, and one was provided indicating that the licensee only provides annual training. Record review of the available documentation did not indicate that the licensee provides annual	0 810		

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0 810	Continued From page 16 training to residents who can assist in their own evacuation on the proper actions to take in the event of a fire to include movement, evacuation, or relocation as required by statute. Record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that the drills were conducted on 2/14/23 at 9:00 p.m. with no further drills being documented. UPL-C verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

Type: Full
Date: 03/01/23
Time: 12:00:29
Report: 1029231033

Food and Beverage Establishment Inspection Report

Page 1

Location:

Senior Living LLC
8478 - 8480 Adair Avenue N
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:

ID #: 0041072
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
ID #:

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

The following orders were issued during this inspection.

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.11A

**** Priority 1 ****

MN Rule 4626.0270A Do not allow food to contact surfaces of equipment and utensils that are not cleaned and sanitized.

Dishwasher not certified to NSF/ANSI Standard 184. Timothy indicated he would immediately obtain sanitizer to hand mix sanitizer solution and would put in an order with the director to obtain a dishwasher with verifiable sanitizing.

Comply By: 03/01/23

4-300 Equipment Numbers and Capacities

4-302.13B

**** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

Maximum temperature registering device or sticker not present to verify dishwasher's highest temperature. Instructed Timothy to provide method of verifying sanitizing temperatures in dishwasher that is used for sanitizing.

Comply By: 03/03/23

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

Thomasia Naya's ServSafe certificate posted but not the certified food protection manager ("CFPM") certificate. Instructed Timothy to have the CFPM certificate posted.

Comply By: 03/10/23

Type: Full
Date: 03/01/23
Time: 12:00:29
Report: 1029231033
Senior Living LLC

Food and Beverage Establishment Inspection Report

Page 2

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

Accumulation of food debris in some of the cabinetry and drawers. Instructed Timothy to have the areas cleaned and maintained clean.

Comply By: 03/02/23

4-600 Cleaning Equipment and Utensils

4-602.12

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

Interior of microwave encrusted with splattered food debris. Instructed Timothy to have microwave cleaned and maintained clean.

Comply By: 03/02/23

Food and Equipment Temperatures

Process/Item: milk

Temperature: 33 Degrees Fahrenheit - Location: refrigerator

Violation Issued: No

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

Conducted inspection with Timothy Oyedokun, House Manager, and one other staff member. Establishment serves one highly susceptible resident, aged 63 years. Discussed all identified issues with Timothy during and after the inspection. Employee illness reporting and exclusion procedures, common foodborne illness pathogens, and a vomit/fecal matter cleanup procedure were also discussed in addition to general food safety practices. The main issue identified was the establishments inability to sanitized kitchenware due to the dishwasher not having been labeled with the needed Certification to NSF/ANSI Standard 184. Alternative methods for sanitizing were discussed, and Timothy indicated he would obtain the correct sanitizer to sanitize kitchenware until they were able to obtain a new dishwasher that has claims made by the manufacturer regarding the equipment's certification to NSF/ANSI Standard 184. Timothy stated that he would contact the director to have a dishwasher installed that is certified to NSF/ANSI Standard 184, and would continue to hand mix sanitizer solution in the interim.

Kitchen had vinyl flooring, smooth painted ceiling and walls, laminate countertops, and wood/composite wood cabinetry and drawers with intact laminate interior surfaces. The areas behind the sink where the laminate countertop met the wall and the juncture between the laminate countertop surface and the short laminate extension up the wall had gaps. I informed Timothy that the gaps would need to be sealed/eliminated to prevent water intrusion and possible sugar/fat intrusion into the MDF countertop material and interior wall area. Timothy stated that he would have the gaps eliminated.

Type: Full
Date: 03/01/23
Time: 12:00:29
Report: 1029231033
Senior Living LLC

Food and Beverage Establishment Inspection Report

Page 3

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 1029231033 of 03/01/23.

Certified Food Protection Manager: Thomasia Evelyn Naya

Certification Number: FM110134 Expires: 03/10/25

Signed: _____

Timothy Oyedokun
House Manager

Signed: 

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029231033

Food Establishment Inspection Report



Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out

3

Date 03/01/23

No. of Repeat RF/PHI Categories Out

0

Time In 12:00:29

Legal Authority MN Rules Chapter 4626

Time Out

Senior Living LLC

Address

8478 - 8480 Adair Avenue N

City/State

Brooklyn Park, MN

Zip Code

55443

Telephone

License/Permit #
0041072

Permit Holder

Purpose of Inspection
Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

IN=in compliance

OUT=not in compliance

N/O=not observed

N/A=not applicable

COS=corrected on-site during inspection

R=repeat violation

Compliance Status		COS	R
Supervision			
1	IN OUT		
PIC knowledgeable; duties & oversight			
2	IN OUT N/A		
Certified food protection manager; duties			
Employee Health			
3	IN OUT		
Mgmt/Staff; knowledge, responsibilities & reporting			
4	IN OUT		
Proper use of reporting, restriction & exclusion			
5	IN OUT		
Procedures for responding to vomiting & diarrheal events			
Good Hygienic 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 procedure 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 procedures 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

Compliance Status		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 labeled; 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			

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

Food Recalls:

Person in Charge (Signature)

Date: 03/02/23

Inspector (Signature)