Electronically Delivered

June 18, 2024

Licensee
Rest Care Home Services, LLC
2421 West 98th Street
Bloomington, MN 55431

RE: Project Number(s) SL37035015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 30, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

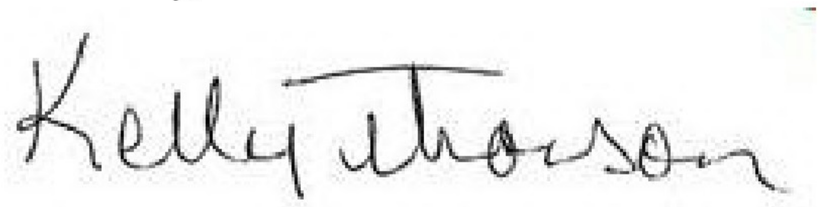
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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

If you have any questions, please contact me.

Sincerely,



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37035	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST CARE HOME SERVICES LLC	2421 WEST 98TH STREET BLOOMINGTON, MN 55431

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37035015 On May 28, through May 30, 2024, the Minnesota Department of Health conducted an intial survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents; all receiving services under the provider's 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.	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460		

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0 460	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 the residents). The findings include: On May 28, 2024, at 10:35 a.m., licensed assisted living director (LALD)-A stated they do	0 460		

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0 460	Continued From page 2 not have a system in place for resident to summon staff 24/7. LALD-A further stated he thought call pendants could be on an as needed basis because all the residents were independent. The licensee's undated Criteria for Admission policy indicated the licensee will provide a means for assisted living residents to request assistance for health and safety needs 24 hours per day, seven days per week from the establishment or a person or entity that has an arrangement with the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 460		
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: 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	0 480		

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0 480	Continued From page 3 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated May 28, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the required information related to the grievance procedure.	0 550		

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0 550	Continued From page 4 This had the potential to affect all the licensee's 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) 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 lacked a posting of the grievance procedure, including the name, telephone number and e-mail contact information for the individuals who were responsible for handling resident grievances. On May 28, 2024, at 2:00 p.m., the surveyor observed the entry area and common areas within the facility and noted there was no required posting of the grievance procedure. On May 28, 2024, at 2:25 p.m., clinical nurse supervisor (CNS)-C stated many of the postings are taken down repeatedly by residents who all have mental health issues. The complaint procedure gets taken down often, but all residents and their families know about who to call for any issues. The licensee's undated Resident Admission Process policy indicated the admission professional will provide the resident/representative with a copy and an explanation of the assisted living bill of rights and the procedures for filing a complaint.	0 550		

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0 550	Continued From page 5 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content.	0 680		

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0 680	Continued From page 6 This had the potential to impact all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On May 30, 2024, at 8:45 a.m., licensed assisted living director (LALD)-A stated the emergency plan had not been completely developed, it needs to be modified, and they will work on updating it. The licensee's undated Emergency Preparedness policy indicated [the facility] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No additional information 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	0 780		

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0 780	Continued From page 7 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 the actuation of one alarm causes all alarms in the dwelling unit to actuate. And the licensee failed to provide working smoke alarm in sleeping room #1 and outside, in the immediate vicinity of sleeping room #1. 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	0 780		

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0 780	Continued From page 8 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 28, 2024, at 12:00 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, it was observed a smoke alarm was not installed in the resident's sleeping room #1 and immediately outside of sleeping room #1 on the main level. It was also observed sleeping rooms that were equipped with smoke alarms were not interconnected upon testing so actuation of one alarm would cause all alarms to operate. During the interview on May 28, 2024, at 12:30 p.m., LALD-A stated the smoke alarms in the facility were not interconnected, and confirm the licensee failed to provide sake alarm in the bedroom #1 and immediately outside of sleeping room #1 on the main level. 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; (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	0 790		

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0 790	Continued From page 9 maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to perform the required annual and monthly maintenance on fire extinguishers and failed to provide adequately rated portable fire extinguishers as required. 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). The findings include: On May 28, 2024, at 12:00 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. It was observed the fire extinguisher did not have a service tag showing it had been inspected annually and lacked records to show the required monthly visual inspections were performed on the portable fire extinguishers. On May 28, 2024, at 12:30 p.m., LALD-A verified the required annual and monthly maintenance had not been completed on the portable fire extinguishers.	0 790		

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0 790	Continued From page 10 TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) 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 drill.	0 810		

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0 810	Continued From page 11 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements and failed to conduct required evacuation drills 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On May 29, 2024, at 9:30 a.m., the licensed assisted living director (LALD)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN During the facility tour, it was observed that emergency evacuation plans were not posted or readily available throughout the facility. During the interview on May 29, 2024, at 10:00 a.m., LALD-A provided a copy of the emergency evacuation plans. However, the provided fire safety and evacuation plan did not show the number of resident rooms.	0 810		

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0 810	Continued From page 12 The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The FSEP was provided by a third-party consultant, and it was not updated to meet the facility-specific layout. The FSEP included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym as the fire safety procedure and included the following discrepancies: - The FSEP indicated residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility was a residential home and did not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. - The FSEP indicated when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and residents are to remain behind these doors. The facility did not have any doors that are on magnetic door holders or doors that are rated for smoke and fire. The facility also did not have a fire alarm system that supports the use of magnetic door holders. During the interview on May 29, 2024, at 10:00 a.m., LALD-A stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. DRILLS Record review of the available documentation indicated the licensee did not conduct evacuation drills twice per year per shift as required by statute. Provided documentation indicated drills	0 810		

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	37035	A. BUILDING: _____ B. WING _____	05/30/2024

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0 810	Continued From page 13 were conducted for the first and second shifts, and the facility failed to provide two drills for the third shift. During the interview on May 29, 2024, at 10:00 a.m., LALD-A stated drills were conducted in the morning and afternoon and confirmed that the facility conducted only one drill for the night shift. LALD-A verified there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff received dementia training in the required areas for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01490		

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01490	Continued From page 14 The findings include: ULP-B started employment with licensee on June 2, 2018. On May 29, 2024, at 8:45 a.m., the surveyor observed ULP-B administer medications. ULP-B's employee file lacked evidence of completing dementia care training in the topics: - an explanation of Alzheimer's disease and other dementia's - assistance with activities of daily living - problem solving with challenging behaviors - communication skills and - person-centered planning and service delivery. On May 30, 2024, at 9:00 a.m., licensed assisted living director (LALD)-A stated he was not aware of all the specific topics required for dementia training and would ensure ULP-B and all staff received his training. The licensee's undated Dementia Care Training policy indicated areas of required training include: An explanation of Alzheimer's Disease and other dementias Assistance with activities of daily living Problem solving with challenging behaviors Communication skills Person centered planning and service delivery No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01490		

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01500	Continued From page 15	01500		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss.	01500		

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01500	Continued From page 16 Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee received at least eight hours of annual training for each 12 months of employment for one of one employee (unlicensed personnel (ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: ULP-B had a hire date of June 2, 2018. On May 29, 2024, at 8:45 a.m., the surveyor observed ULP-B administer medications.	01500		

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01500	Continued From page 17 ULP-B's record lacked evidence of annual training to include effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. On May 30, 2024, at 9:03 a.m., licensed assisted living director (LALD)-A stated none of the staff had been trained on that topic, it had not been assigned for anyone including ULP-B. LALD-A further stated he will make sure everyone gets it completed right away. The licensee's undated Annual Training Requirements policy indicated annual training must include effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01620 SS=F	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	01620		

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01620	Continued From page 18 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 by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) used the uniform assessment tool for ongoing assessments and monitoring for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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 May 27, 2024, at 10:30 a.m., clinical nurse supervisor (CNS)-C stated the licensee completed initial, 14-day, 90-day, and change in condition assessments.	01620		

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01620	Continued From page 19 R1 was admitted and began receiving services on September 20, 2020. R1's most recent assessment dated April 7, 2024, did not include all the required elements on the uniform assessment tool. R1's assessment lacked: -personal lifestyle preferences, including sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life, spiritual and cultural preferences, and advance health care directives and end-of-life preferences -instrumental activities of daily living including housework and laundry and transportation On May 30, 2024, at 9:10 a.m., licensed assisted living director (LALD)-A stated he was not familiar with the uniform assessment tool and was not sure why some of the pieces were missing. On May 30, 2024, at 12:45 p.m., clinical nurse supervisor (CNS)-C stated the electronic medical record they use is missing some of the information for the assessment, they have the physical part but are lacking the mental/spiritual part. They are currently looking into a using a different electronic medical record. The Minnesota Administrative Rule 4659.0150 dated August 11, 2021, indicated each facility must develop a uniform assessment tool to include all the required elements. The licensee's undated Comprehensive Resident Assessment policy indicated the initial comprehensive assessment must be conducted in person by a registered nurse and include the following elements: personal lifestyle preferences	01620		

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01620	Continued From page 20 including sleep schedule, dietary needs, leisure activities, spiritual and cultural preferences, and advance health directives. Activities of daily living including toileting, dressing, grooming, bathing, mobility, dental status, oral care and eating. Independent activities of daily living including ability to self-manage medications, laundry and transportation needs. Physical health status including a relevant health history and current health conditions, allergies and sensitivities to medications, environment, and food and if any of these are life threatening. In addition to general health status/system assessment, the agency comprehensive assessment tool will include: demographics and client history, living arrangement and support systems, integumentary status, neuro/emotional/behavioral status, functional limitations in completing activities of daily living, assessment of all medication the client is taking, vulnerability and safety assessment to determine risk of being abused and risk of abusing others, nutritional assessment to identify those at risk due to inadequate fluid and food availability or willingness of client to follow plan, equipment needs and ability to manage equipment, identification of advance directives, POLST, or specific emergency response instructions the client has and coordinating inclusion of those wishes into a resident's plan of care, emergent care data, items collected at resident's facility admission and discharge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

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01650	Continued From page 21	01650		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure resident service plans included all the required content for one of one resident (R1). This practice resulted in a level two violation (a	01650		

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01650	Continued From page 22 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: R1's service plan dated August 1, 2021, lacked the following: -the methods of monitoring assessments of the resident -the schedule and methods of monitoring staff providing services On May 30, 2024, licensed assisted living director (LALD)-A stated they do not have the most up to date form to use for the resident's service plans and was not aware that some of the required information was missing. The licensee's undated Service Plan policy indicated the service plan will include: -the schedule and methods of monitoring assessments of the resident -the schedule and methods of monitoring staff providing services No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01710 SS=F	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and	01710		

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01710	Continued From page 23 reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication reassessments for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 admitted to the facility and began receiving services on September 20, 2020. On May 29, 2024, at 8:45 a.m., the surveyor observed ULP-B administer medications to R1. R1's service plan dated August 1, 2021, indicated R1 received services to include medication administration and behavior management. R1's medication assessment was dated September 24, 2021. On May 30, 2024, at 1:12 p.m., clinical nurse supervisor (CNS)-C stated he had not been	01710		

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01710	Continued From page 24 completing annual medication assessments and was not aware of the requirement. The licensee's undated Individualized Medication Management Plan and Record policy indicated the registered nurse (RN) will monitor and reassess the resident's medication management services as needed at the nurse's periodic monitoring visits (at least every 90 days or more frequently based on the RN's judgement). No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;	01730		

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01730	Continued From page 25 (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication management record to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include:	01730		

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01730	Continued From page 26 On May 29, 2024, at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R1. R1's record included a medication assessment dated September 24, 2021. The medication management plan lacked the following: - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services On May 30, 2024, at 1:12 p.m., clinical nurse supervisor (CNS)-C stated the forms they were using for the medication plans had missing requirements. CNS-C further stated they are looking into getting updated forms to use to meet requirements. The licensee's undated Individualized Medication Management Plan and Record policy indicated following completion of the nursing assessment, including an assessment of the resident's need for medication management, the RN (registered nurse) develops an individualized medication management record for the resident in conjunction with the resident and/or the resident's representatives. The plan must include the following: procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01770	Continued From page 27	01770		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R1's record lacked medication set-up documentation to include dates of medication set-up, name of medication, quantity of dose, times to be administered, routes of administration, and name of person completing medication set-up. On May 29, 2024, at 1:10 p.m., clinical nurse supervisor (CNS)-C stated when he completed a medication set-up, he just writes a nursing note and was not aware of all the documentation requirements for medication set-ups.	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37035	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST CARE HOME SERVICES LLC	2421 WEST 98TH STREET BLOOMINGTON, MN 55431

(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
01770	Continued From page 28 The licensee's undated Medication Set-up policy indicated the facility will set up medications for residents as ordered by the physician/prescriber. Medications will be set up using weekly med-planner or computerized dispensing systems with verbal reminder capability. A medication administration record or other medication documentation method should be used to set up medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37035	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST CARE HOME SERVICES LLC	2421 WEST 98TH STREET BLOOMINGTON, MN 55431

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01910	Continued From page 29 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include the medication strength, prescription number, quantity, date of disposition, and names of staff and other individuals involved in the disposition. 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: R2 discharged from licensee on October 2, 2023. R2's discharge summary dated October 3, 2023, indicated R2 received medication management services. R2's record lacked evidence of documentation of R2's disposition of medications to include name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On May 30, 2024, at 1:12 p.m., clinical nurse supervisor (CNS)-C stated he was not aware of the requirements for documentation of disposition of medications.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37035	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REST CARE HOME SERVICES LLC	2421 WEST 98TH STREET BLOOMINGTON, MN 55431

(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 30 The licensee's undated Medication Disposition or Disposal policy indicated disposition of unused or discontinued prescription drugs managed by our facility will have documentation of the destruction, listing the date, quantity, name of drug, prescription number, signature of the person destroying the drugs and signature of the witness to the destruction must be recorded in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entryway of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37035	A. BUILDING: _____ B. WING _____	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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03090	Continued From page 31 a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On May 28, 2024, at 2:00 p.m., the surveyor observed the lack of an electronic monitoring notice to visitors with the correct verbiage posted. The sign posted indicated 'This area is under 24-hour video surveillance'. On May 28, 2024, at 2:11 p.m., clinical nurse supervisor (CNS)-C stated they do not have the correct verbiage for electronic monitoring and was not aware their sign was not sufficient. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *05/28/24*
Time: 10:00:31
Report: 1050241110

Food and Beverage Establishment Inspection Report

Location:
Rest Care Home Services Llc
2421 West 98th Street
Bloomington, MN55431
Hennepin County, 27

Establishment Info:
ID #: 0038544
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123270670
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority.

MISSING ILLNESS LOG COPY SUPPLIED VIA EMAIL. DISCUSSED TRACKING SPECIFIC SICKNESSES. COMPLY WITH RULE ABOVE.

Comply By: 05/30/24

2-100 Supervision

2-102.12AMN

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

FACILITY CURRENTLY HAS A SERVSAFE CERTIFICATION UNDER THE NAME SAAMBE VARNEY WITH EXPIRATION 12/17/27. DISCUSSED PROCESS TO OBTAIN MN CFPM CREDENTIAL. INSTRUCTIONS SUPPLIED VIA EMAIL. COMPLY WITH RULE ABOVE.

Comply By: 07/30/24

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.

OBSERVED MICROWAVE COVERED IN LEFT OVER FOOD DEBRIS. DISCUSSED ESTABLISHING A FREQUENCY SET TO KEEP CAVITY CLEAN. COMPLY WITH RULE ABOVE.

Comply By: 05/30/24

Type: Full
Date: *05/28/24*
Time: 10:00:31
Report: 1050241110
Rest Care Home Services Llc

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cold Holding/ MILK
Temperature: 41F Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

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

Floor updated one year ago to vinly plank along with countertops. Food is provided to residents with leftovers thrown out after two day freeze. Current pest management contract with Orkin no pests were scene on site.

Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse Information on food recalls available "MDA Food Recall"
https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota.

Discussed employee health and hygiene, exclusion for individuals from the kitchen with vomiting and/or diarrheal illness, sore throat with fever, or reportable illness; food cooking and holding temperatures, cross-contamination, allergens, food storage order in refrigerator, separating resident food from medication or staff food, avoiding bare hand contact with foods which will not be cooked (cut fruit, deli sandwiches), pest control.

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 1050241110 of 05/28/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Sambe Varney
Owner

Signed:_____
Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us

Report #: 1050241110

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	3
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 05/28/24
Time In 10:00:31
Time Out

Rest Care Home Services Llc	Address: 2421 West 98th Street	City/State: Bloomington, MN	Zip Code: 55431	Telephone: 6123270670
License/Permit #: 0038544	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Food Recalls:

Person in Charge (Signature) **Date:** 05/30/24

Inspector (Signature)