Electronically Delivered

August 21, 2025

Licensee
Blaine White Pine
12446 Jamestown Street Northeast
Blaine, MN 55449

RE: Project Number(s) SL30650016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 2, 2025, 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 . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in

a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

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
	30650	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAINE WHITE PINE	12446 JAMESTOWN STREET NE BLAINE, MN 55449

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30650016-0 On June 30, 2025, through July 2, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 66 residents; 66 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 130 SS=C	144G.12, Subd. 1 Application for Licensure Each application for an assisted living facility	0 130		

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0 130	Continued From page 1 license, including provisional and renewal applications, must include information sufficient to show that the applicant meets the requirements of licensure, including: (1) the business name and legal entity name of the licensee, and the street address and mailing address of the facility; (2) the names, e-mail addresses, telephone numbers, and mailing addresses of all owners, controlling individuals, managerial officials, and the assisted living director; (3) the name and e-mail address of the managing agent and manager, if applicable; (4) the licensed resident capacity and the license category; (5) the license fee in the amount specified in section 144.122; (6) documentation of compliance with the background study requirements in section 144G.13 for the owner, controlling individuals, and managerial officials. Each application for a new license must include documentation for the applicant and for each individual with five percent or more direct or indirect ownership in the applicant; (7) evidence of workers' compensation coverage as required by sections 176.181 and 176.182; (8) documentation that the facility has liability coverage; (9) a copy of the executed lease agreement between the landlord and the licensee, if applicable; (10) a copy of the management agreement, if applicable; (11) a copy of the operations transfer agreement or similar agreement, if applicable; (12) an organizational chart that identifies all organizations and individuals with an ownership interest in the licensee of five percent or greater	0 130		

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0 130	Continued From page 2 and that specifies their relationship with the licensee and with each other; (13) whether the applicant, owner, controlling individual, managerial official, or assisted living director of the facility has ever been convicted of: (i) a crime or found civilly liable for a federal or state felony level offense that was detrimental to the best interests of the facility and its resident within the last ten years preceding submission of the license application. Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud, and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pretrial diversions; any felonies involving malpractice that resulted in a conviction of criminal neglect or misconduct; and any felonies that would result in a mandatory exclusion under section 1128(a) of the Social Security Act; (ii) any misdemeanor conviction, under federal or state law, related to: the delivery of an item or service under Medicaid or a state health care program, or the abuse or neglect of a patient in connection with the delivery of a health care item or service; (iii) any misdemeanor conviction, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service; (iv) any felony or misdemeanor conviction, under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in Code of Federal Regulations, title 42, section 1001.101 or	0 130		

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0 130	Continued From page 3 1001.201; (v) any felony or misdemeanor conviction, under federal or state law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance; (vi) any felony or gross misdemeanor that relates to the operation of a nursing home or assisted living facility or directly affects resident safety or care during that period; (vii) any revocation or suspension of a license to provide health care by any state licensing authority. This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority; (viii) any revocation or suspension of accreditation; or (ix) any suspension or exclusion from participation in, or any sanction imposed by, a federal or state health care program, or any debarment from participation in any federal executive branch procurement or nonprocurement program; (14) whether, in the preceding three years, the applicant or any owner, controlling individual, managerial official, or assisted living director of the facility has a record of defaulting in the payment of money collected for others, including the discharge of debts through bankruptcy proceedings; (15) the signature of the owner of the licensee, or an authorized agent of the licensee; (16) identification of all states where the applicant or individual having a five percent or more ownership, currently or previously has been licensed as an owner or operator of a long-term care, community-based, or health care facility or agency where its license or federal certification has been denied, suspended, restricted, conditioned, refused, not renewed, or revoked	0 130		

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0 130	Continued From page 4 under a private or state-controlled receivership, or where these same actions are pending under the laws of any state or federal authority; (17) statistical information required by the commissioner; and (18) any other information required by the commissioner. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to hold an assisted living with dementia care license for their current capacity of residents. The assisted living with dementia care license effective December 1, 2024, indicated a capacity of 63 residents, however 66 residents resided at the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee's resident roster dated June 30, 2025, identified a total resident census of 66; 66 receiving services within the building under the assisted living with dementia care license. The licensee's application for an assisted living license, signed by authorized agent (AA)-M on August 27, 2024, indicated the capacity was 63 residents. On July 1, 2025, at 12:00 p.m., director of	0 130		

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0 130	Continued From page 5 operations (DO)-A stated she thought they had increased the capacity from 63 to 67 to accommodate for married couples living in the same apartment but did not have any evidence that this had been completed. On July 7, 2025, at 2:30 p.m., clinical nurse supervisor (CNS)-C confirmed via email that all residents listed on the facility roster received services. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 130		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;	0 480		

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0 480	Continued From page 6 (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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.	0 480		

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0 480	Continued From page 7 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, June 30, 2025, 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		
0 680 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	0 680		

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0 680	Continued From page 8 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 post an emergency disaster plan prominently and develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, employees, 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) 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's EPP lacked the required content: - missing resident quarterly review; - the development of policies/procedures to address: - use of volunteers; - arrangement with other facilities; and - roles under a waiver declared by secretary;	0 680		

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0 680	Continued From page 9 - names and contact information for staff, entities providing services, resident physicians, other facilities, and volunteers; and - exercises to test the EPP at least twice per year, including unannounced drills using the EPP. On June 30, 2025, at 2:55 p.m., director of operations (DO)-A stated she agrees some of the required content of the EPP is missing and this included some of the policies, missing person quarterly review, and the EPP testing. The licensee's 9.10 Emergency Preparedness Plan-Appendix Z Compliance policy dated April 1, 2024, indicated the licensee's emergency preparedness plan will include all required elements of appendix Z. The licensee's 2.28 Missing Resident policy dated August 1, 2021, indicated, the licensee will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subd. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 10 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with Minnesota State Fire Code in Minnesota Rules chapter 7511. 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). The findings include: On July 1, 2025, the surveyor toured the facility with maintenance (M)-E. The following was observed. 1. The facility is equipped with magnetic locks on the exit doors. M-E confirmed that there was not a switch or button that was able to release the magnetic locking devices from a remote location. The egress control locking system shall have the capability of being unlocked by a signal or switch from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock. 2. The 3rd level fire rated door on the north end of the facility did not close and latch. Swinging fire doors shall close from the full-open position and	0 775		

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0 775	Continued From page 11 latch automatically. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but 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:	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30650	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLAINE WHITE PINE	12446 JAMESTOWN STREET NE BLAINE, MN 55449

(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
0 780	Continued From page 12 Based on observation and interview, the licensee failed provide interconnected smoke alarms in required locations. These deficient conditions 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). The findings include: On July 1, 2025, the surveyor toured the facility with maintenance (M)-E. During the tour, the surveyor observed the smoke alarms were tested for interconnection by the licensee, in dwelling unit 34 smoke alarms were not interconnected as required by state statute. During the facility tour interview on July 1, 2025, M-E acknowledged the observation while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
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	0 800		

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	30650	A. BUILDING: _____ B. WING _____	07/02/2025

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BLAINE WHITE PINE	12446 JAMESTOWN STREET NE BLAINE, MN 55449

(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 13 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, 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 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). The findings include: On July 1, 2025, the surveyor toured the facility with maintenance (M)-E. The following was observed. GENERAL MAINTENANCE: Waterlines in the parking garage mechanical room were unsupported. The anchors securing the water line hangers pulled out, and the hangers were unsecured. On July 1, 2025, M-E acknowledged the observation while accompanying on the tour.	0 800		

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0 800	Continued From page 14 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) staff 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) Staff 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 staff 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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	30650	A. BUILDING: _____ B. WING _____	07/02/2025

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0 810	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required training. 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) 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: TRAINING: The licensee failed to provide evacuation training to residents at least once per year. M-E lacked documentation showing any training was offered for residents on the fire safety and evacuation plan. On July 1, 2025, M-E stated they understood the requirements for training residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly	01290		

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	30650	A. BUILDING: _____ B. WING _____	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01290	Continued From page 16 scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated to the current health facility identification (HFID) number for five of five employees on the facility provided employee roster licensed assisted living director (LALD)-H and unlicensed personnel (ULP) I, ULP-J, ULP-K and ULP-L. 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: On June 30, 2025, at 12:30 p.m., the surveyor reviewed the facility's NetStudy 2.0 roster	01290		

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01290	Continued From page 17 (background study) and compared it to the facility's staff roster and discovered five employees were not affiliated with the licensee's HFID #30650. On July 1, 2025, at 1:15 p.m., director of operations (DO)-A stated the employees were not affiliated with this HFID due to either starting at another sister facility or the temporary staffing agency the company owns and when they started working at this facility the affiliation was missed. The licensee's 4.02 Background Studies policy dated April 1, 2025, indicated [the facility] will conduct a Minnesota Department of Human Services background study on all employees and volunteers and contractors at [the facility]. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
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	01500		

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01500	Continued From page 18 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. 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	01500		

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01500	Continued From page 19 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 annual training included all required topics for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-F and ULP-G. 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-F was hired on September 8, 2022, to perform direct care services to the licensee's residents. ULP-G was hired on August 9, 2022, to perform direct care services to the licensee's residents. ULP-F and ULP-G's employee records lacked evidence annual training had been completed as required in the following areas: - Review of provider's policies and procedures. On July 1, 2025, at 12:15 p.m., clinical nurse supervisor (CNS)-D stated she does not have evidence the ULP's had completed the annual training on the review of providers policies and procedures but has added it to the annual training checklist to ensure they have documentation of	01500		

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01500	Continued From page 20 this training for future surveys. The licensee's 5.06 Annual Required Staff Training policy dated April 1, 2025, indicated the following training elements must be included every 12 months to all staff who performs direct care services: - review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees	01640		

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01640	Continued From page 21 when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee or resident or resident's representative to document agreement of services to be provided for two of three residents (R2 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 was admitted to the licensee for assisted living services on February 21, 2025. R2's Individual Service Plan Agreement with effective date February 21, 2025, was not signed by the resident or their representative. R3 was admitted to the licensee for assisted living services on April 4, 2023. R3's Individual Service Plan Agreement with effective date July 3, 2024, was not signed by the resident or their representative.	01640		

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01640	Continued From page 22 On July 1, 2025, at 9:33 a.m., regional registered nurse (RRN)-C stated R2's service plan was sent to family to be signed but they did not receive it back, they did follow up with family in March but still did not receive it. RRN-C stated when they realized it was not signed yesterday, they reached out to family and were able to get a signed copy back for R2. On July 1, 2025, at :30 p.m., RRN-C stated the service plan for R3 was sent to family to sign but it does not appear to have been signed and returned. The licensee's 6.08 Service Plan policy dated April 1, 2025, indicated within 14 days after the date that services are first provided to a resident, the licensee will finalize a written service plan. The Service plan and any revision shall include a signature or other authentication by licensee and by the resident, or resident's representative, documenting agreement on the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

Blaine WP LLC
12446 Jamestown Street NE
Blaine, MN 55449
Anoka County
Parcel:

Phone: 763-754-1930
wwellner@wpseniorliving.com

License Info

License: HFID 0650
Blaine Wellner
Risk:
License:
Expires on:
CFPM: ANDREW BEANE
CFPM #: 66738; Exp: 8/19/2027

Inspection Info

Report Number: F1029251046
Inspection Type: Full - Single
Date: 6/30/2025 Time: 12:11:32 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 7
Delivery:

New Order: 2-100 Supervision
2-103.11D,G,H,I,K,M *Priority Level: Priority 2 CFP#: 1*
MN Rule 4626.0035DGHIKM The person in charge must ensure employees follow proper food handling procedures, including: effectively wash their hands; prevent cross-contamination of ready-to-eat food with bare hands by using suitable food utensils such as deli tissue, spatulas, tongs, single-use gloves, or proper dispensing equipment; properly cook TCS foods and verify cooking temperatures with a temperature measuring device; properly cool TCS foods that will not be held hot or consumed within 4 hours; maintain TCS foods at proper hot and cold holding temperatures; plumbing cross connection control, and properly sanitize cleaned multiuse equipment and utensils by monitoring the exposure time and concentration of the chemical sanitizing rinse solution, or by monitoring the exposure time and temperature for hot water sanitizing.
COMMENT: STAFF'S FOOD AND BEVERAGE IN SAME COOLER AS ESTABLISHMENT FOOD SUPPLY. PERSON IN CHARGE (PIC) INSTRUCTED TO ENSURE THE STAFF'S FOODS AND BEVERAGES ARE CLEARLY IDENTIFIED AND SEPARATED FROM ESTABLISHMENT FOOD, IF THE SAME COOLER IS SHARED, TO PREVENT POSSIBLE COMMINGLING AND/OR CONTAMINATION OF FOODS AND BEVERAGES SERVED TO THE HIGHLY SUSCEPTIBLE POPULATION PRESENT AT THE ESTABLISHMENT. PIC INSTRUCTED TO IMPLEMENT ACTIVE MANAGERIAL CONTROL TO ENSURE STAFF COMPLY WITH FOOD SAFETY REQUIREMENTS TO PREVENT THE SPREAD OF FOODBORNE ILLNESS.
Comply By: 6/30/2025 Originally Issued On: 6/30/2025

New Order: 3-300B Protection from Contamination: cross-contamination, eggs
3-302.12 *Priority Level: Priority 3 CFP#: 37*
MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.
COMMENT: ITEMS IN MAIN KITCHEN COOLER WITHOUT IDENTIFIERS. PIC INSTRUCTED TO LABEL FOODS TO ALLOW FOR IDENTIFICATION.
Comply By: 6/30/2025 Originally Issued On: 6/30/2025

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-305.12 *Priority Level: Priority 3 CFP#: 39*
MN Rule 4626.0305 Do not store food in locker rooms, toilet rooms, dressing rooms, garbage rooms, mechanical rooms, under unprotected sewer lines, under leaking water lines, under water lines on which water has condensed, under open stairwells, or under other sources of contamination.
COMMENT: 2-DOOR UPRIGHT COOLER AND 2-DOOR UPRIGHT FREEZER IN BASEMENT MECHANICAL ROOM UNDER WATER AND SEWER LINES. PIC INSTRUCTED TO MOVE EQUIPMENT OUT OF AREA TO PROTECT FROM POSSIBLE CONTAMINATION.
Comply By: 7/11/2025 Originally Issued On: 6/30/2025

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: 2-DOOR UPRIGHT EC ECONOMY REFRIGERATOR IN MAIN KITCHEN NOT MAINTAINING SAFE TEMPERATURES. TEMP ABUSED FOODS IDENTIFIED AND DISCARDED BY PIC. PIC INSTRUCTED TO ADJUST, REPAIR, OR REPLACE COOLER TO ENSURE SAFE HOLDING TEMPS AND TO NOT PLACE ANY ADDITIONAL TCS FOODS INTO COOLER UNTIL SAFE TEMPS ARE VERIFIED.
Comply By: 6/30/2025 Originally Issued On: 6/30/2025

New Order: 3-500C Microbial Control: date marking
3-501.17A *Priority Level: Priority 2 CFP#: 23*
MN Rule 4626.0400A Mark the refrigerated, ready-to-eat, TCS food prepared and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded.
COMMENT: PREPARED TCS ITEMS IN MAIN KITCHEN COOLER WITHOUT DATE MARKINGS. ITEMS KNOWN TO BE LESS THAN 7 DAYS OLD. PIC INSTRUCTED TO ENSURE REQUIRED ITEMS BEAR A DATE MARK.
Comply By: 6/30/2025 Originally Issued On: 6/30/2025

New Order: 4-200 Equipment Design and Construction
4-201.11AMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: MEMORY CARE COOLER IS RESIDENTIAL. COLD HOLDING EQUIPMENT MUST BE COMMERCIAL IN NATURE IF ESTABLISHMENT IS NOT EXCLUSIVELY DOING SAME-DAY SERVICE.
Comply By: 7/11/2025 Originally Issued On: 6/30/2025

New Order: 4-200 Equipment Design and Construction
4-204.112A *Priority Level: Priority 3 CFP#: 36*
MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.
COMMENT: INDEPENDENT INTERNAL THERMOMETER ABSENT FROM MAIN KITCHEN COOLER. CORRECTED DURING INSPECTION. PIC PLACED THERMOMETER INTO COOLER. PIC INSTRUCTED TO VERIFY SAFE HOLDING TEMPS WITH THE INTERNAL THERMOMETER.
Comply By: 6/30/2025 Originally Issued On: 6/30/2025

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: EC ECONOMY REFRIGERATOR IN MAIN KITCHEN NOT MAINTAINING SAFE COLD HOLDING TEMPS. PIC INSTRUCTED TO HAVE COOLER REPAIRED OR REPLACED.
Comply By: 6/30/2025 Originally Issued On: 6/30/2025

New Order: 6-200 Physical Facility Design and Construction
6-202.11A *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.1375A Provide effective shielding, coated or shatter-resistant light bulbs for all light fixtures where there is exposed food, clean equipment, utensils and linens, or unwrapped single-service or single-use articles.
COMMENT: PLASTIC SHIELDING COVERING CEILING TUBE LIGHTS IN DISHWASHING AREA CRACKED AND MISSING IN AREAS. REPAIR OR REPLACE.
Comply By: 7/4/2025 Originally Issued On: 6/30/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: BUILDUP OF FOOD DEBRIS AND RESIDUES UNDER DRY STORAGE RACKS. CLEAN AND MAINTAIN CLEAN TO PREVENT INVITING CONDITIONS FOR PESTS.
Comply By: 6/30/2025 Originally Issued On: 6/30/2025

Food & Beverage General Comment

INSPECTION CONDUCTED AS PART OF AN HRD NURSING SURVEY OF AN ASSISTED LIVING FACILITY. ALL IDENTIFIED ISSUES REVIEWED WITH ANDREW BEANE, ESTABLISHMENT REPRESENTATIVE, THROUGHOUT INSPECTION.

TOPICS COVERED: EMPLOYEE ILLNESS LOGGING, EXCLUSION, AND NOTIFICATION REQUIREMENTS; EMPLOYEE HYGIENE AND HANDWASHING; BAREHAND CONTACT WITH READY TO EAT FOODS AND NOROVIRUS; GLOVE AND UTENSIL USE; SANITIZING; PROTECTION FROM CONTAMINATION; SUPERVISORY REQUIREMENTS AND ACTIVE MANAGERIAL CONTROL; TEMPERATURE CONTROL; DATE MARKING; CHARACTERISTICS OF QUATERNARY AMMONIUM COMPOUNDS AND BINDING; AND ADDITIONAL REQUIREMENTS FOR SERVING A HIGHLY SUSCEPTIBLE POPULATION.

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

I acknowledge receipt of the Metro District Office inspection report number F1029251046 from 6/30/2025

Trevor McCliment

ANDREW BEANE
EXECUTIVE CHEF - PERSON IN CHARGE (PIC)

Trevor McCliment,
Public Health Sanitarian 3
651-201-3957
trevor.mccliment@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

Blaine WP LLC
Blaine
County/Group: Anoka County

Inspection Info

Report Number: F1029251046
Inspection Type: Full
Date: 6/30/2025
Time: 12:11:32 PM

New Record: **Product/Item/Unit:** BUTTER PACKETS; **Temperature Process:** COLD HOLDING
Location: 2-DOOR UPRIGHT - MAIN KITCHEN at 54 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** BUTTER PACKETS; **Temperature Process:** COLD HOLDING
Location: 2-DOOR UPRIGHT - MAIN KITCHEN at 55 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** CHOPPED ICEBURG LETTUCE; **Temperature Process:** COLD HOLDING
Location: 2-DOOR UPRIGHT - MAIN KITCHEN at 55 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** HARD BOILED EGGS; **Temperature Process:** COLD HOLDING
Location: 2-DOOR UPRIGHT - MAIN KITCHEN at 52 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** GRATED PARMESAN; **Temperature Process:** COLD HOLDING
Location: 2-DOOR UPRIGHT - MAIN KITCHEN at 55 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** OPENED APPLE SAUCE; **Temperature Process:** COLD HOLDING
Location: 2-DOOR UPRIGHT - MAIN KITCHEN at 48 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** OPENED SALSA; **Temperature Process:** COLD HOLDING
Location: 2-DOOR UPRIGHT - MAIN KITCHEN at 48 Degrees F.
Comment:
Violation Issued?: Yes

New Record: **Product/Item/Unit:** GRAVY; **Temperature Process:** JUST COOKED AND SERVING
Location: COUNTER at 178 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** MASHED POTATOES; **Temperature Process:** JUST COOKED AND SERVING
Location: COUNTER at 168 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** MILK; **Temperature Process:** COOLING FROM DELIVERY
Location: BASEMENT MECHANICAL ROOM COOLER at 43 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** BUTTER; **Temperature Process:** COLD HOLDING
Location: BASEMENT MECHANICAL ROOM COOLER at 41 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** MILK; **Temperature Process:** COOLING - JUST OUT FOR SERVICE
Location: MEMORY CARE COOLER at 45 Degrees F.
Comment:
Violation Issued?: No

New Record: **Product/Item/Unit:** SALSA; **Temperature Process:** COLD HOLDING
Location: MEMORY CARE COOLER at 41 Degrees F.
Comment:
Violation Issued?: No

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Establishment Info

Blaine WP LLC
Blaine
County/Group: Anoka County

Inspection Info

Report Number: F1029251046
Inspection Type: Full
Date: 6/30/2025
Time: 12:11:32 PM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 168 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** QUATERNARY AMMONIUM**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 200 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** QUATERNARY AMMONIUM**; Sanitizing Process:** Dispenser
Location: Dishwashing Area **Equal To** 300 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1029251046

Food Establishment Inspection Report

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

No. of Risk Factor/Intervention/Violations	3	Date: 6/30/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 12:11:32 PM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Blaine WP LLC	12446 Jamestown Street NE	Blaine, MN	55449	763-754-1930
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 0650	Blaine Wellner	Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

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

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

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

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

			COS	R
		Safe Food and Water		
30	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36	X	Thermometers provided & accurate		
		Food Identification		
37	X	Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39	X	Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47	X	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	X	Physical facilities installed, maintained & clean		
56	X	Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Trevor McClime

Follow-up: Follow-up Date: