



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 21, 2022

Administrator
PSC Of New Ulm LLC
1304 Birchwood Drive
New Ulm, MN 56073

RE: Project Number SL30771015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 17, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

Please address your cover letter for general reconsideration requests to:

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

Free from Maltreatment reconsideration requests should be addressed to:

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

PSC Of New Ulm LLC

July 21, 2022

Page 3

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

Sincerely,

A handwritten signature in cursive script, reading "Jess Gallmeier".

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/17/2022
NAME OF PROVIDER OR SUPPLIER PSC OF NEW ULM LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 BIRCHWOOD DRIVE NEW ULM, MN 56073		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30771015 On June 14, 2022 through June 16, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 15 residents, all of whom received services under the provider's Assisted Living Dementia Care 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	0 460		

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 460	Continued From page 1 assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide a means for residents to request assistance for health and safety needs as required. The licensee did not have a system in place for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all 18 residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 460		

Minnesota Department of Health

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0 460	Continued From page 2 The findings include: The licensee held an assisted living with dementia care license and was licensed for a bed capacity of twenty residents. During the entrance conference on June 15, 2022, at approximately 10:20 a.m., registered nurse (RN)-A confirmed the licensee did not have a call system in place for residents to request assistance when needed. RN-A stated all staff were able to hear residents should they call out for assistance due to the two units being small. RN-A also stated that some of the residents had tab alarms (an audible alarm system that is connected to the resident's clothing and sounds if the resident attempts to move from where they are either sitting or lying). During the facility tour on June 15, 2022, at 11:35 a.m., the surveyor noted the licensee had two units where residents resided. Each resident's room had a wood paneled door, and each door had a door knob that would be used to close a door. Each resident room lacked any type of calling system to notify staff when assistance would be needed. During interview on June 15, 2022, at approximately 1:45 p.m., R1 stated she did not have a tab alarm (an alarm system attached to the clothing being worn by a resident) on her person or her bed or any other call system supplied by the licensee, and she felt staff were not always able to hear her when she was in her room. R1 stated there had been issues in the past where she had fallen, and the staff had not heard her yelling out for help. R1 had requested the previous director install a bell on her walker	0 460		

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0 460	Continued From page 3 for her to use when she needed assistance in her room. This was installed in 2021 and R1 stated she has been using it. R1 also stated that staff do hear her ring the bell and they come to her room to assist. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the	0 470		

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0 470	Continued From page 4 appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop or implement a staffing plan to determine its staffing level. This had the potential to affect all 15 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license, effective August 1, 2021. The licensee was licensed for a resident capacity of 20 residents and had a current census of 15 residents. During the entrance conference on June 15, 2022, at approximately 10:30 a.m., assisted living director (ALD)-D explained how the licensee staffed its building. ALD-D stated the licensee did have a daily staffing scheduled posted in the staff office but was not sure what a staffing plan was. The surveyor explained what a staffing plan was and ALD-D reiterated the licensee had not developed a staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 470		

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0 470	Continued From page 5 (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (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 had the potential to affect all 15 residents in the Assisted Living with Dementia Care 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	0 480		

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0 480	Continued From page 6 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated June 16, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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 e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. 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 and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all the	0 550			

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0 550	Continued From page 7 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, 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 June 15, 2022, at approximately 11:30 a.m., during a facility-wide tour, the surveyor did not observe a posting of the required grievance procedure content in a conspicuous place. On June 15, 2022, at approximately 12:05 p.m., assisted living director (ALD)-D confirmed the required grievance procedure content had not been posted . The licensee's Vulnerable Adult Maltreatment policy, dated August 1, 2021, did not include the new Assisted Living Licensure requirements related to posting information in a conspicuous place. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with	0 780		

Minnesota Department of Health

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0 780	Continued From page 8 the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed provide smoke alarms in all sleeping rooms throughout the facility. 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).	0 780		

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0 780	Continued From page 9 Findings include: On a facility tour on June 16, 2022, at approximately 10:40 a.m. with Regional Assisted Living Director (RALD)-C and Assisted Living Director (ALD)-D it was observed that smoke alarms were not installed in sleeping rooms as required by statute. The licensee did provide smoke detectors as part of the central fire alarm system in the sleeping rooms, but these devices provided no audible warning within the room as the required smoke alarm would. An interview with RALD-C and ALD-D verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year	0 810		

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0 810	Continued From page 10 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. This MN Requirement is not met as evidenced by: Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on June 16, 2022, at approximately 9:30 a.m. with	0 810		

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0 810	Continued From page 11 Regional Assisted Living Director (RALD)-C and Assisted Living Director (ALD)-D on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee had minimal employee actions listed under the fire drill procedure but did not have the actions listed out in the plan. During interview, RALD-C stated that the fire safety and evacuation plan lacked further provisions for employee actions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, RALD-C stated that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The licensee did provide limited procedures for physical needs but did not address cognitive needs of the residents as it pertained to movement, evacuation, or relocation. The licensee's plan also prescribed different ambulatory levels for residents for evacuation but did not apply these levels to the actual residents. During interview, RALD-C verified this deficient finding. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30771	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/17/2022
NAME OF PROVIDER OR SUPPLIER PSC OF NEW ULM LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1304 BIRCHWOOD DRIVE NEW ULM, MN 56073		
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0 810	Continued From page 12 evacuation plan twice per year after the training it initial hire. During interview, RALD-C stated that employee training was conducted annually but could not provide a policy or documentation to verify. Record review of the available documentation indicated that the licensee did not conduct evacuation drills every other month as required by statute. The provided documentation indicted that the licensee conducted one drill dated 6/13/22 but the documentation did not indicate that any sort of form of evacuation was conducted. During interview, RALD-C stated that the licensee had only conducted the one drill since August 1, 2021, and that there was no further documentation to provide. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	02040		

Minnesota Department of Health

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02040	Continued From page 13 Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on June 16, 2022, at approximately 9:30 a.m. with Regional Assisted Living Director (RALD)-C and Assisted Living Director (ALD)-D on the hazard vulnerability assessment for the physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, RALD-C stated that licensee had conducted a hazard vulnerability assessment for the emergency disaster plan for the facility but had not conducted a hazard vulnerability assessment of the physical environment with mitigation factors on and around the property to date at the time of survey. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Minnesota Department of Health

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02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and (2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals with dementia. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: RN-A had a hire date of August 23, 2021, and provided supervision and training to unlicensed personnel (ULP) in the licensee's assisted living with dementia care establishment. During the entrance conference on June 15, 2022, at approximately 10:30 a.m., assisted living director (ALD)-D stated registered nurse (RN)-A	02140		

Minnesota Department of Health

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02140	Continued From page 15 oversaw training staff in the care of individuals with dementia. On June 15, 2022, at approximately 12:00 p.m., ALD-D stated RN-A had not completed an approved competency and knowledge test required for supervising staff in an assisted living facility with dementia care; however, ALD-D stated RN-A was currently working on the required training in dementia care needed to obtain competency/certification. No further information was provided. TIME PERIOD TO CORRECT: Twenty-One (21) days	02140		
02410 SS=E	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan.	02410		

Minnesota Department of Health

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02410	Continued From page 16 Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure privacy in double occupancy room for six of 15 residents (R1, R2, R3, R4, R5, R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On June 15, 2022, at approximately 11:29 a.m., during the facility tour with assisted living director (ALD)-D, the surveyor noted R1 and R2 to be in a shared room. The room lacked any type of privacy curtain or partition to assure privacy for residents with a shared room. On June 15, 2022, at 12:22 p.m., ALD-D verified the double occupancy rooms at the establishment did not have a privacy curtain/screen/partition. ALD-D stated they usually try to take one resident out of the room if they are providing care to the roommate. ALD-D also stated during cares, such as dressing, grooming and incontinence care,	02410		

Minnesota Department of Health

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02410	Continued From page 17 staff would bring the resident to the restroom to assure privacy as it would not be possible to assure privacy for residents with a shared room due to lack of divider curtains. A list of the double occupancy rooms without privacy curtains was requested and provided. The list identified the following residents shared a double occupancy room without privacy curtains: -R1 and R2 -R3 and R4 -R5 and R6 The Minnesota Bill of Rights for Assisted Living Residents dated May 16, 2021, indicates that residents have the right for personal and treatment privacy. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02410		



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

Type: Full
Date: 06/16/22
Time: 09:03:32
Report: 1020221067

Food and Beverage Establishment Inspection Report

Page 1

Location:

Psc Of New Ulm Llc
1304 Birchwood Drive
New Ulm, MN56073
Brown County, 08

Establishment Info:

ID #: 0038201
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5073593420
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.

2-100 Supervision

2-102.12AMN

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

PERSON IN CHARGE HAS TAKEN A CERTIFIED FOOD PROTECTION MANAGER (CFPM) COURSE, BUT HAS NOT COMPLETED THE INITIAL CFPM FORM TO BE CERTIFIED IN MINNESOTA. FORM WAS PROVIDED WITH THE REPORT.

Comply By: 06/30/22

4-200 Equipment Design and Construction

4-201.11AMN

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.

THE DOMESTIC DISHWASHERS USED IN BOTH THE FARM AND LAKESIDE KITCHENS DO NOT REACH TEMPERATURES HIGH ENOUGH TO MEET THE UTENSIL SURFACE REQUIREMENT TO REACH 160F. ACCORDING TO SPECIFICATION SHEETS THEY ARE NOT DESIGNED FOR LICENSED FOOD ESTABLISHMENTS.

Comply By: 08/31/23

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - UPRIGHT FREEZER, FARM SIDE KITCHEN

Violation Issued: No

Type: Full
Date: 06/16/22
Time: 09:03:32
Report: 1020221067
Psc Of New Ulm Llc

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: CHEESE - UPRIGHT COOLER, FARM SIDE KITCHEN

Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: DELI MEAT - UPRIGHT COOLER, LAKE SIDE KITCHEN
Violation Issued: No

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

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

GENERAL COMMENTS:

DISCUSSED EMPLOYEE ILLNESS POLICIES AND PROCEDURES. AN EMPLOYEE ILLNESS LOG IS USED ON-SITE.

FACT SHEET ON MINNESOTA CERTIFIED FOOD PROTECTION MANAGER PROVIDED WITH THE REPORT.

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 1020221067 of 06/16/22.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: Report emailed
Establishment Representative

Signed: Ashley B
Ashley B

651-201-4500

Report #: 1020221067

Food Establishment Inspection Report



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

No. of RF/PHI Categories Out

1

Date 06/16/22

No. of Repeat RF/PHI Categories Out

0

Time In 09:03:32

Legal Authority MN Rules Chapter 4626

Time Out

Psc Of New Ulm Llc

Address

1304 Birchwood Drive

City/State

New Ulm, MN

Zip Code

56073

Telephone

5073593420

License/Permit #
0038201

Permit Holder

Purpose of Inspection

Full

Est Type

Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

IN= in compliance

OUT= not in compliance

N/O= not observed

N/A= not applicable

COS= corrected on-site during inspection

R= repeat violation

Compliance Status

COS R

Supervision

1	IN	OUT	PIC knowledgeable; duties & oversight		
2	IN	OUT	Certified food protection manager, duties		

Employee Health

3	IN	OUT	Mgmt/Staff; knowledge, responsibilities & reporting		
4	IN	OUT	Proper use of reporting, restriction & exclusion		
5	IN	OUT	Procedures for responding to vomiting & diarrheal events		

Good Hygienic Practices

6	IN	OUT	N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN	OUT	N/O	No discharge from eyes, nose, & mouth		

Preventing Contamination by Hands

8	IN	OUT	N/O	Hands clean & properly washed		
9	IN	OUT	N/A	No bare hand contact with RTE foods or pre-approved alternate procedure properly followed		
10	IN	OUT		Adequate handwashing sinks supplied/accessible		

Approved Source

11	IN	OUT		Food obtained from approved source		
12	IN	OUT	N/A	Food received at proper temperature		
13	IN	OUT		Food in good condition, safe, & unadulterated		
14	IN	OUT	N/A	Required records available; shellstock tags, parasite destruction		

Protection from Contamination

15	IN	OUT	N/A	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	Proper cooking time & temperature		
19	IN	OUT	N/A	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	Proper cooling time & temperature		
21	IN	OUT	N/A	Proper hot holding temperatures		
22	IN	OUT	N/A	Proper cold holding temperatures		
23	IN	OUT	N/A	Proper date marking & disposition		
24	IN	OUT	N/A	Time as a public health control: procedures & records		

Consumer Advisory

25	IN	OUT	N/A	Consumer advisory provided for raw/undercooked food		
----	----	-----	-----	---	--	--

Highly Susceptible Populations

26	IN	OUT	N/A	Pasteurized foods used; prohibited foods not offered		
----	----	-----	-----	--	--	--

Food and Color Additives and Toxic Substances

27	IN	OUT	N/A	Food additives: approved & properly used		
28	IN	OUT		Toxic substances properly identified, stored, & used		

Conformance with Approved Procedures

29	IN	OUT	N/A	Compliance with variance/specialized process/HACCP		
----	----	-----	-----	--	--	--

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

GOOD RETAIL PRACTICES

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

Mark "X" in box if numbered item is **not** in compliance

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

COS= corrected on-site during inspection

R= repeat violation

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	Plant food properly cooked for hot holding		
35	IN	OUT	N/A	Approved thawing methods used		
36				Thermometers provided & accurate		

Food Identification

37				Food properly labeled; original container		
----	--	--	--	---	--	--

Prevention of Food Contamination

38				Insects, rodents, & animals not present		
39				Contamination prevented during food prep, storage & display		
40				Personal cleanliness		
41				Wiping cloths: properly used & stored		
42				Washing fruits & vegetables		

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	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				Physical facilities installed, maintained, & clean		
56				Adequate ventilation & lighting; designated areas used		
57				Compliance with MCIAA		
58				Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature)

Report emailed

Date: 06/17/22

Inspector (Signature)

Mhy RUC