Electronically Delivered

April 7, 2022

Administrator
Fieldcrest Assisted Living
80 Vermillion Street East
Cottonwood, MN 56229

RE: Project Number(s) SL36858015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on March 9, 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

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

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

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36858	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELDCREST ASSISTED LIVING	80 VERMILLION STREET EAST COTTONWOOD, MN 56229

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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: SL36858015 On, March 7, 2022, through March 9, 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 21 residents, all of whom recieved servcies under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (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 21 residents residing 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 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report	0 480		

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0 480	Continued From page 2 dated March 8, 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, in a conspicuous place, 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. This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 550		

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0 550	Continued From page 3 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 lacked a posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, there was no evidence of 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, or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). During a facility tour on March 7, 2022, at approximately 10:30 a.m., the common areas shared by residents, staff, and visitors, lacked the required posting of the grievance procedure and contact information for the Ombudsman. On March 8, 2022, at approximately 12:21 p.m. licensed assisted living director (LALD)-D acknowledged the required content was not posted in the common areas. The licensee's Complaint Policy and Procedure dated May 2021, identified "Each client and/or client representative, as appropriate, receives written information about how to file a complaint with the Offices of Health Facility Complaints and the Ombudsman for Long-Term Care, in accordance with the Home Care Bill of Rights. Each home care client also receives written information on our agency's procedures for	0 550		

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0 550	Continued From page 4 submitting a complaint about our services, including a statement that there will be no retaliation because of a complaint. Every effort is made to appropriately receive, investigate, and resolve complaints and to avoid any form of retaliation." The policy failed to identify the information was required to be posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers	0 660		

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0 660	Continued From page 5 for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of three employees, (unlicensed personnel (ULP)-H) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-H's personnel file identified she was hired on September 14, 2020. ULP-H had a tuberculosis screening and a first step TST administered on September 14, 2020. Her file lacked evidence a second step TST had been completed. On March 9, 2022, at 12:57 p.m. licensed assisted living director/registered nurse (LALD/RN)-D confirmed only a first step TST was documented in ULP-H's file, and further stated ULP-H should have had a second step TST. The licensee's Tuberculosis Risk Assessment Policy & Procedures dated October 2021, identified "Each employee who will have contact with patients on a regular basis while performing their role with [the licensee] is required to have a two-step Mantoux test prior to engagement with [the licensee's] patients or Interferon Gamma	0 660		

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0 660	Continued From page 6 Release Assay (IGRA) TB blood test. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an 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 7 missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. The licensee failed to maintain testing and maintenance records for the emergency generator. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: The licensee's Emergency Preparedness Plan dated October 2021, included a Hazard and Vulnerability Assessment Tool and policies and procedures related to natural and man-made disasters, as well as generic provisions on how staff should respond in various situations; however, the licensee's plan lacked the following	0 680		

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0 680	Continued From page 8 required content: -an assessment of the at risk population's needs; -a process for emergency preparedness (EPS) cooperation with state and local EPS officials/organizations; -procedure for tracking staff during an evacuation; -an evacuation plan to include staff responsibilities during an evacuation; -a plan for how the facility would provide a means to shelter in place for residents, staff and volunteers; and -development of emergency staffing strategies to include volunteers. The EPS communication plan lacked the following required content: -contact information for federal, state, regional EPS staff, state licensing and certification agency and Office of the State Long Term Care Ombudsman; -a means of providing information about the facilities needs and its ability to provide assistance to include information about their occupancy; and -a method for sharing information from the emergency plan with residents and their families. GENERATOR The facility failed to provide the required testing and inspection record keeping information for review of the standby emergency generator as part of the EPP (shelter-in-place) to ensure proper performance during a power outage: -records of the required emergency generator monthly load test in accordance with NFPA 110; and -records of the required weekly emergency generator maintenance and inspections as outlined under NFPA 110.	0 680		

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0 680	Continued From page 9 On March 9, 2022, at approximately 3:51 p.m. quality manager (QM)-C confirmed she believed the licensee had all required components of the EPP developed; however, during further discussion, QM-C agreed some areas could be more developed. The employee who previously maintained the generator was no longer with the company and generator testing and maintenance records were not maintained. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility.	0 810		

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0 810	Continued From page 10 (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 interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to provide required employee training on fire safety and evacuation. 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 March 7, 2022, between approximately 1:00 p.m. and 1:35 p.m. with chief executive officer (CEO)-A, Quality Manager (QM)-C, and Maintenance Supervisor (MS)-B on the fire safety and evacuation plan and fire safety and	0 810		

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0 810	Continued From page 11 evacuation training for the facility. Record review indicated that the fire safety and evacuation plan did not have fire protection procedures necessary for residents. During interview, QM-C stated that the fire safety and evacuation plans did not include provisions for this requirement. Record review indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation in the procedures for resident movement, evacuation, or relocation during a fire or similar emergency. During interview, QM-C stated that the fire safety and evacuation plans did not include provisions for this requirement. Record review indicated that employees did not receive training twice per year after initial hire on the facility fire safety and evacuation plan. During interview, QM-C stated that the licensee provides training on fire safety annually and indicated that the facility policy requires employees to be trained on fire safety annually. Record review indicated that the licensee did not provide training to residents who are capable of self-evacuation on the proper actions to be taken in the event of a fire in regard to movement, evacuation, and relocation. During interview, QM-C stated that the licensee does not provide this training to residents. Record review indicated that that the licensee did not conduct evacuation drills every other month as required by statute. During interview, QM-C stated that the licensee had conducted drills, but documentation was not on site at this facility.	0 810		

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FIELDCREST ASSISTED LIVING	80 VERMILLION STREET EAST COTTONWOOD, MN 56229

(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
0 810	Continued From page 12 QM-C stated that documentation would be provided via email as a follow up. Review of the provided documented drills indicated that the licensee had conducted fire drills in September of 2021 and then January 2022. Documented drills did not reference evacuation and were not conducted every other month as required. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01370 SS=E	144G.61 Subd. 2 Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating;	01370		

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01370	Continued From page 13 (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care for two of two employees, unlicensed personnel (ULP-E and ULP-H) 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: ULP-E ULP-E began providing assisted living services for the provider on August 17, 2021.	01370		

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01370	Continued From page 14 On March 7, 2022, at 12:02 p.m., ULP-E was observed to check a blood glucose and administer insulin and eye drops. ULP-E's employee record lacked evidence to indicate ULP-E completed training and/or practical skills evaluations as required in the following area: -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; and -standby assistance techniques and how to perform them. ULP-H ULP-H began providing assisted living services for the provider on August 1, 2021; however, she began working for the employer on September 14, 2020, under the comprehensive license. On March 8, 2022, from 8:30 a.m. to approximately 9:00 a.m., ULP-H was observed to administer medications to several residents. ULP-H's employee record lacked evidence to indicate ULP-H completed training and/or practical skills evaluations as required in the following area: -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; and -understanding appropriate boundaries between staff and clients and the client's family On March 9, 2022, at 2:19 p.m. licensed assisted living director/registered nurse (LALD/RN)-D	01370		

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01370	Continued From page 15 verified ULP-E and ULP-H's employee files lacked evidence of completed training and/or practical skills evaluations as required The licensee's Orientation and Training Requirements form, undated, failed to identify training and/or practical skills evaluations as required in the following area: -training on the prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; and -understanding appropriate boundaries between staff and clients and the client's family The licensee's Training and Competency Evaluation of Unlicensed Staff policy dated May 2021, identified "Unlicensed home care personnel will meet all orientation and training requirements and will be determined to be competent to perform all assigned tasks by the RN or by other Licensed Health Professional, when appropriate, before unlicensed personnel may provide any service to a home care client." "Following are the required training topics for unlicensed personnel, with notation regarding the type of competency evaluation that is required" included the following: -training on the prevention of falls for providers working with the elderly or individuals at risk of falls (written or oral test required); -standby assistance techniques and how to perform them (practical skills test required); -medication, exercise and treatment reminders (written or oral test required); and -understanding appropriate boundaries between staff and clients and the client's family (written or oral test required).	01370		

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01370	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01370		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of	01440		

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01440	Continued From page 17 providing services for two of two unlicensed personnel (ULP-E and ULP-H) 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 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: ULP-E ULP-E began providing assisted living services for the provider on August 17, 2021. On March 7, 2022, at 12:02 p.m. ULP-E was observed to check blood glucose and administer insulin and eye drops. ULP-E's employee file lacked evidence the RN conducted direct supervision of the employee performing a delegated task within 30 days the employee had first performed the delegated task for residents. ULP-H ULP-H began providing assisted living services for the provider on August 1, 2021; however, she began working for the employer on September 14, 2020, under the comprehensive license. On March 8, 2022, from 8:30 a.m. to approximately 9:00 a.m., ULP-H was observed to administer medications to several residents, and at 1:30 p.m. ULP-H was observed providing catheter cares.	01440		

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01440	Continued From page 18 ULP-H's employee file lacked evidence the RN conducted direct supervision of the employee performing a delegated task within 30 days the employee had first performed the delegated task for residents. On March 9, 2022, at 2:19 p.m. licensed assisted living director/registered nurse (LALD/RN)-D verified direct supervision of the employees performing a delegated task within 30 days the employee had first performed the delegated task for residents had not been completed. She was unaware of the requirement. The licensee's Supervision of Licensed and Unlicensed Personnel dated May 2021, noted direct supervision of ULP by an RN would be completed within 30 calendar days after the staff member began working and first performed delegated tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=E	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services;	01470		

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01470	Continued From page 19 (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01470		

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01470	Continued From page 20 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living facility statutes included all the required content for three of three employees (unlicensed personnel (ULP)-E, ULP-H, and licensed assisted living director/registered nurse (LALD/RN)-D) 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: ULP-E. ULP-H, and LALD/RN-D's employee files lacked evidence their orientation contained the following topics as required: -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. ULP-E ULP-E began providing assisted living services for the provider on August 17, 2021.	01470		

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01470	Continued From page 21 On March 7, 2022, at 12:02 p.m. ULP-E was observed to check blood glucose and administer insulin and eye drops. ULP-H ULP-H began providing assisted living services for the provider on August 1, 2021; however, she began working for the employer on September 14, 2020, under the comprehensive license.. On March 8, 2022, from 8:30 a.m. to approximately 9:00 a.m., ULP-H was observed to administer medications to several residents. LALD/RN-D LALD/RN-D began providing assisted living services for the provider on August 1, 2021; however, she began working for the employer on September 27, 2019, under the comprehensive license. On March 9, 2022, at 2:19 p.m., LALD/RN-D confirmed the employees listed above had not completed principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. The licensee's Orientation and Training Requirements form, undated, failed to identify training as required in the following area: -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. The licensee's Training and Competency Evaluation of Unlicensed Staff policy dated May, 2021, identified "Unlicensed home care personnel will meet all orientation and training requirements and will be determined to be competent to perform all assigned tasks by the RN or by other	01470		

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01470	Continued From page 22 Licensed Health Professional, when appropriate, before unlicensed personnel may provide any service to a home care client." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01470		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication	01730		

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01730	Continued From page 23 management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individualized medication management record with the required content for one of three residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On March 7, 2022, at 12:02 p.m., unlicensed personnel (ULP)-E administered Novolog insulin to R1. R1's service plan dated August 1, 2021, indicated R1 received medication management services.	01730		

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01730	Continued From page 24 R1's prescriber orders dated February 16, 2022 included orders for Novolog and Tresiba insulins R1's Individualized Medication Management Plan dated March 8, 2022, identified medication management tasks that may be delegated to unlicensed personnel included eye drops. The plan failed to identify insulin administration was delegated to unlicensed personnel. R1's March 2022 Medication Sheet listed medications as prescribed, including Novolog and Tresiba insulins, times to administer, and staff initials on each date to indicate the medications had been given. On March 8, 2022, at approximately 2:11 p.m., licensed assisted living director/registered nurse (LALD/RN)-A verified the medication management plan failed to identify insulin administration was delegated to unlicensed personnel. The licensee's Medication Management Services policy dated May 2021, identified "the RN will develop an individualized medication management plan for each client receiving any type of medication management services, consistent with current practice standards and guidelines, and will develop specific procedures for medication management services that staff will provide. The RN will assure that unlicensed personnel are trained, competent and oriented to the client whenever unlicensed personnel are to perform medication management services for the client." No further information was provided.	01730		

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01730	Continued From page 25 TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for one of two residents (R1) with medication storage 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On March 7, 2022, at 12:02 p.m. during a medication administration observation, unlicensed personnel (ULP)-E administered Novolog insulin to R1. Upon review of R1's medications, it was noted the Novolog insulin	01890		

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01890	Continued From page 26 failed to have an open or expiration date identified on the pen. In addition, the Tresiba lacked the original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been dispensed. ULP-E confirmed the findings and stated staff were to date the medication when they were opened. On March 7, 2022, licensed assisted living director/registered nurse (LALD/RN)-D verified the above findings and stated staff were to follow the policy of dating upon opening; further, all medications should have a pharmacy label. The manufacturer's instructions for Novolog dated June 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's directions for Tresiba dated December 2016, directed the pen should be thrown away after 56 days if it is refrigerated or kept at room temperature, even if it still has insulin left in it and the expiration date has not passed. A policy regarding labeling of medications was requested but was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36858	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELDCREST ASSISTED LIVING	80 VERMILLION STREET EAST COTTONWOOD, MN 56229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 27 the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the disposition of medications, including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition for one of one discharged resident (R4) with record review. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36858	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELDCREST ASSISTED LIVING	80 VERMILLION STREET EAST COTTONWOOD, MN 56229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 28 only occasionally). The findings include: R4's discharge summary dated January 26, 2022, identified R4 was admitted December 21, 2021. R4 received medication management services and assistance with activities of daily living. R4 was discharge on January 14, 2022, due to inability to meet R4's needs. R4's disposition of meds included the medication, strength, quantity and how the medication was destroyed for the following medications: -alendronate (osteoporosis); -aspirin (heart health); -calcium (supplement); -milk of magnesia (constipation); -Miralax (constipation); -mirtazapine (anti-depressant); -omega Q plus (supplement); -potassium (potassium replacement); -simvastatin (cholesterol); -vision multi (supplement); -vitamin C (supplement); -vitamin D3 (supplement); and -zolpidem (sedative for sleep); The documentation lacked the pharmacy prescription numbers for these medications. On March 7, 2022, at 2:12 p.m. licensed assisted living director/registered nurse (LALD/RN)-D confirmed the missing content and stated that all of the medication dispositions would be missing the required content of prescription numbers. The licensee's Disposition or Disposal of Medication policy dated May 2021, identified "Staff will document in the client's record the name of the person to whom the medications were given, the time and date, the name of each	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36858	A. BUILDING: _____ B. WING _____	03/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIELDCREST ASSISTED LIVING	80 VERMILLION STREET EAST COTTONWOOD, MN 56229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 29 medication and the amount of medication remaining." The policy failed to identify the requirement of the pharmacy prescription number. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

DEPARTMENT OF HEALTH

Type: Full
Date: *03/08/22*
Time: 11:04:00
Report: 1030221002

Food and Beverage Establishment Inspection Report

Location:
Fieldcrest Assisted Living
80 Vermillion Street East
Cottonwood, MN56229
Lyon County, 42

Establishment Info:
ID #: 0038592
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5074236691
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.

7-200 Toxic Supplies and Applications

7-204.11 ** Priority 1 **

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

Ecolab Smartpower Sink & Surface Sanitizer (EPA Reg. No. 1677-260) spray bottle on food prep area was tested to have a concentration > 3010 PPM. EPA approved range is 704 to 1875 PPM. Auto dispenser adjusted. PIC refilled spray bottle and retested concen

Corrected on Site

4-500 Equipment Maintenance and Operation

4-502.11C

MN Rule 4626.0820C Ambient air temperature, water pressure, and water temperature measuring devices must be accurate within the intended range of use and maintained in good repair.

Observed separated column of the ambient thermometer in the Arctic Air #2 upright cooler located in the food prep area. PIC state they will check food temperatures with thermometer until it is replaced.

Comply By: 03/10/22

Surface and Equipment Sanitizers

Acid Ecolab SmartPower: > 3010 at Degrees Fahrenheit
Location: Spray bottle - food prep
Violation Issued: Yes

Acid Ecolab Smart Power: = 1875 at Degrees Fahrenheit
Location: Adjusted dispenser & refilled spray bottle
Violation Issued: No

Hot water: at 166.7 Degrees Fahrenheit
Location: NSF dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Roast beef - cooking
Temperature: 171.4 Degrees Fahrenheit - Location: Oven
Violation Issued: No

Process/Item: Corn - cooking
Temperature: 156.2 Degrees Fahrenheit - Location: Stove top
Violation Issued: No

Process/Item: Potato salad
Temperature: 35.1 Degrees Fahrenheit - Location: Frigiidaire #1 upright cooler food prep
Violation Issued: No

Process/Item: Ambient
Temperature: 38.3 Degrees Fahrenheit - Location: Frigidaire #1 upright cooler - food prep
Violation Issued: No

Process/Item: Mashed potatoes
Temperature: 32.5 Degrees Fahrenheit - Location: Arctic Air #2 upright cooler - food prep
Violation Issued: No

Process/Item: Frigidaire upright freezer
Temperature: -20 Degrees Fahrenheit - Location: Ambient - laundry storage area
Violation Issued: No

Process/Item: Arctic Air upright freezer
Temperature: -18 Degrees Fahrenheit - Location: Ambient - food storage area
Violation Issued: No

Process/Item: Advant Edge upright freeze
Temperature: -20 Degrees Fahrenheit - Location: Ambient - food storage area
Violation Issued: No

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

This was an inspection completed in conjunction with MDH Health Regulations Division survey and requested by Stacy Haag, HRD team lead.

All violations were discussed with the PIC, facility CEO and MDH HRD team lead.

The following was discussed with the PIC and facility CEO, and educational fact sheets were emailed to the facility CEO.

Employee illness policy and log
Certified Food Protection Manager renewal
Food preparation (same day service)
Cooling procedures (from ambient temperatures)

Food and Beverage Establishment Inspection Report

Food temperatures
Thermometer use and calibration
Hand Washing and prevention of bare hand contact
Date marking procedures
Sanitizer use and test kit
Serving highly susceptible populations - using only pasteurized eggs and juice
Cleaning and sanitizing food contact surfaces and utensils

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the inspection report number 1030221002 of 03/08/22.

Certified Food Protection Manager: Thomas Jackson

Certification Number: FM67805 Expires: 12/07/23

Inspection report reviewed with person in charge and emailed.

Signed: _____

Sarah Kirchner
Chief Executive Officer

Signed: Denise Schumacher

Denise Schumacher

Marshall DO
denise.schumacher@state.mn.us

Report #: 1030221002

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	0	Date	03/08/22
No. of Repeat RF/PHI Categories Out	0	Time In	11:04:00
Legal Authority MN Rules Chapter 4626		Time Out	

Fieldcrest Assisted Living	Address: 80 Vermillion Street East	City/State: Cottonwood, MN	Zip Code: 56229	Telephone: 5074236691
License/Permit #: 0038592	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47	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) **Date:** 03/09/22

Inspector (Signature) Denise Lund