DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

December 20, 2021

Administrator
Edgemont Place Alzheimer's
11748 Ulysses Lane Northeast
Blaine, MN 55434

RE: Project Number(s) SL32457015-1

Dear Administrator:

On December 9, 2021, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 29, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-215-9697

PMB

Electronically Delivered

October 26, 2021

Administrator
Edgemont Place Alzheimer's Spe
11748 Ulysses Lane Northeast
Blaine, MN 55434

RE: Project Number(s) SL32457015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on October 1, 2021, 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 Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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), immediate fine imposition is authorized for both surveys and investigations conducted. 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. A copy of the provider's records documenting those actions may be requested for follow-up surveys. 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 client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/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.

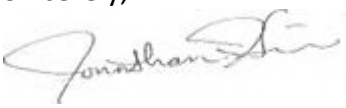
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. 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 addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

Sincerely,



Jonathan Hill, Supervisor
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State Evaluation Team
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P.O. Box 3879
St. Paul, MN 55101-3879
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32457	A. BUILDING: _____ B. WING _____	10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEMONT PLACE ALZHEIMER'S SPE	11748 ULYSSES LANE NE BLAINE, MN 55434

(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 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: SL32457015 On September 27, 2021, through September 29, 2021, 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 41 residents receiving services under the provider's Assisted Living with 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 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 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (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 appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required staffing plan was developed and posted as required. This had the potential to affect all 41 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	0 470		

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0 470	Continued From page 2 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: The licensee failed to develop and implement a staffing plan for determining its staffing level based on the following: (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. During an observation on September 27, 2021, at approximately 10:30 a.m., the surveyors toured the licensee's building, and observed a board with postings that included; the assisted living license, the assisted living director's license and a Clinical Laboratory Improvement Amendment (CLIA), but the staffing plan was missing. On September 29, 2021, at approximately 3:00 p.m., the licensed assisting living director (LALD)-A stated a staffing plan had been developed to address the content listed above, but they did not have a place to post it as the residents will pull it down.	0 470		

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0 470	Continued From page 3 The licensee's undated policy Assisted Living Required Postings And Disclosures, verified the missing posting is required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (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 41 residents of the assisted living facility. This practice resulted in a level two violation (a	0 480		

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0 480	Continued From page 4 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: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated September 27, 2021, 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 and interview, the licensee failed to post in a conspicuous place, information	0 550		

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0 550	Continued From page 5 about the facility's grievance procedure, the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect staff, visitors and all 41 residents receiving assisted living services. 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: On September 27, 2021, at approximately 10:30 a.m., during a facility tour, observation revealed the licensee lacked posting of the above required content in a conspicuous place. On September 29, 2021, at approximately 4:05 p.m., the licensed assisted living director (LALD)-A confirmed the required content had not been posted. The licensee's undated policy, Assisted Living Required Postings And Disclosures, lacked information to include the new Assisted Living Licensure requirements related to posting grievance procedure information in a conspicuous place. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 550		

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0 630 SS=E	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for three of three residents (R1, R3) 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 a 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: R1's Individual Abuse Prevention Plan, dated September 14, 2021, indicated vulnerabilities to	0 630		

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0 630	Continued From page 7 include: -physical abuse: "lack of community orientation skills" with intervention of "staff redirection when and as needed." -self-abuse: "lack of self-preservation skills" with intervention of "staff assistance when and as needed." -financial exploitation: "inability or unwillingness to handle financial matters" with intervention of "POA [power of attorney] to handle all financial obligations." R1's Service Plan dated September 28, 2021, indicated vulnerabilities to include: severe memory impairment, disorientation, and poor judgement. R1's Individual Abuse Prevention Plan and Service Plan lacked statements of specific measures to be taken to minimize the risk of abuse to R1. R3's Service Plan Detail dated May 29, 2021, through December 11, 2021, indicated R3's diagnoses included the following: dementia, and Alzheimer's disease. R3's Individual Abuse Prevention Plan (IAPP) dated September 28, 2021, identified vulnerabilities to include: sexual abuse, physical abuse, self abuse, and financial exploitation but they lacked individualized measures to reduce the risk of abuse to self and by others. On September 27, 2021, at 12:50 p.m., during tour of unit, R1 was observed to monitor the exit door and attempted to follow the surveyors out of the unit door. R1 was redirected by licensee staff away from the door.	0 630		

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0 630	Continued From page 8 On September 29, 2021, at 12:45 p.m., R1 was observed to follow a family member out of the secured memory care unit door. The licensee receptionist intervened and redirected R1 back into the memory care unit. On September 29, 2021, at approximately 4:30 p.m., the director of nursing/registered nurse (DON/RN)-B, acknowledged the residents' IAPP were missing interventions and stated they will work to improve on their interventions. The licensee's policy Vulnerable Adult Maltreatment Policy indicated the licensee would ensure each individual abuse prevention plan included specific measures to be taken to minimize the risk of abuse to others and self-abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with	0 640		

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0 640	Continued From page 9 information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, 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. This had the potential to affect all 41 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: The licensee lacked the following: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. On September 27, 2021, at approximately 10:30 a.m., during a facility tour, observation revealed the licensee lacked posting of the above required information in a conspicuous place.	0 640		

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0 640	Continued From page 10 On September 29, 2021, at approximately 4:25 p.m., licensed assisted living director (LALD)-A verified the required posting was missing and would work to have it posted. The licensee's undated policy, Assisted Living Required Postings And Disclosures, verified the missing posting was required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as	0 650		

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0 650	Continued From page 11 required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records included all required content for one of two employees unlicensed personnel (ULP)-G with employee records reviewed (job description, TB training, and 30-day supervision). 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-G had a hire date of August 2, 2021. On September 29, 2021, at approximately 9:30 a.m., ULP-G was observed to pass medications to the assisted living residents. ULP-G's record lacked evidence of current job description, tuberculosis training at hire, and 30-day supervision when performing delegated tasks.	0 650		

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0 650	Continued From page 12 When interviewed on September 29, 2021, at approximately 4:30 p.m., director of nursing/registered nurse (DON/RN)-B stated that was all the record they found for the employee, but they hoped the contractor for which the employee worked will send them more employee record because she was trained there. The licensee's undated Employee Record policy verified the facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
01470 SS=D	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; (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;	01470		

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01470	Continued From page 13 (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 (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.	01470		

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01470	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of two employees (unlicensed personnel (ULP)-G) received orientation to assisted living facility licensing requirements and regulations 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-G had a hire date of August 2, 2021. On September 29, 2021, at approximately 9:30 a.m., ULP-G was observed to pass medications to the assisted living residents. ULP-G's employee record lacked evidence to indicate the employee had received orientation to include the following topics: - an overview of Assisted Living laws 144G. - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person - handling of emergencies and use of emergency services - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights	01470		

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01470	Continued From page 15 - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - 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 - a review of the types of assisted living services the employee will be providing and the facility's category of licensure On September 29, 2021, at approximately 4:40 p.m., licensed assisted living director (LALD)-A and director of nursing/registered nurse (DON/RN)-B verified ULP-G's record lacked orientation to assisted living licensing requirements and regulations. The licensee's undated Assisted Living & Assisted Living With Memory Care Orientation-All Staff policy indicated newly hired staff would receive orientation and training on topics required for assisted living organizations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t	01650		

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01650	Continued From page 16 (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on record review, and interview, the licensee failed to ensure the service plan included the required content for three of three residents (R1, R2, and R3) 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	01650		

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01650	Continued From page 17 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 the potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included, but was not limited to Alzheimer's disease and renal failure. R1's Service Plan dated September 14, 2021, lacked the following content: -the service of blood sugar management -frequency of each service, according to the resident's current assessment and resident preferences -the contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. R2's diagnoses included, but was not limited to dementia. R2's Service Plan dated August 13, 2019, lacked the following content: -frequency of each service, according to the resident's current assessment and resident preferences. R3's Service Plan Detail dated September 11, 2021, indicated R3 had diagnoses to include, but was not limited to dementia, Alzheimer's disease, and atrial fibrillation. R3's service plan lacked the content to include -frequency of each service, according to the	01650		

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01650	Continued From page 18 resident's current assessment and resident preferences -the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. -information and a method to contact the facility On September 29, 2021, at approximately 4:20 p.m., licensed assisted living director (LALD)-A and director of nursing/registered nurse (DON/RN)- B verified the missing content was supposed to be included in the resident service plan. The licensee's undated policy titled Contents Of The Service Plans, indicated the missing content to be included in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
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;	01730		

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01730	Continued From page 19 (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 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 plan with the required content for one of three residents (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01730		

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01730	Continued From page 20 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: On September 28, 2021, at approximately 9:30 a.m., R3 was observed taking medications form the unlicensed personnel (ULP)-E. R3's Individualized Medication Management Plan dated October 24, 2020, indicated R3 was receiving medication administration daily and as needed. R3's individual medication management plan lacked content to include; (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 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.	01730		

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01730	Continued From page 21 On September 29, 2021, at approximately 4:30 p.m., director of nursing/registered nurse (DON/RN)-B acknowledged the required content was missing and stated it will be added to the resident's medication management plan. The licensee's undated policy Administration Of Medication, Treatment And Therapy By Unlicensed Personnel lacked reference to the required content of individualized medication management plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, record review and interview the licensee failed to ensure medication	01760		

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01760	Continued From page 22 was administered as prescribed for one of three residents (R1) with record reviewed when there was no documentation of blood sugars. 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). Findings include: R1's diagnoses included, but was not limited to Alzheimer's disease and renal failure. R1's prescriber's signed orders dated September 3, 2021, included blood sugar monitoring "test 2 times/day. Reason: High A1C [blood test for type 2 diabetes and prediabetes]." R1's prescriber's unsigned orders dated September 16, 2021, included "check blood glucose twice weekly." R1's September 2021 Medication Administration Record lacked documentation of blood sugar monitoring. On September 29, 2021, at approximately 9:30 a.m., unlicensed personnel (ULP)-E was observed administering the following morning medications to R1; aspirin 81 milligram (mg) tablet, take one tablet by mouth once daily, citalopram hydrobromide 20 mg tablet, take one tablet by mouth every morning, losartan potassium 25 mg tablet, take one tablet by mouth once daily, memantine HCl 10 mg tablet, take	01760		

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01760	Continued From page 23 one tablet by mouth once daily, metformin HCl 1000 mg tablet, take one tablet by mouth two times daily, metoprolol succinate 100 mg tablet, take one tablet by mouth twice daily. On September 29, 2021, at approximately 9:35 a.m., the contents of R1's medication box was observed and revealed there was a blood glucose testing kit in a small black bag. On September 29, 2021, at approximately 9:40 a.m., ULP-E stated the nurse tested R1's blood glucose every morning. On September 29, 2021, at approximately 11:20 a.m., licensed practical nurse (LPN)-H stated that it was her understanding the blood glucose check was only to be done only two times immediately following R1's admission to the assisted living facility. On September 29, 2021, at approximately 4:35 p.m., director of nursing/registered nurse (DON/RN)-B acknowldged there was a discrepancy and stated she will follow up with R1's primary physician to have the orders clarified immediately. The licensee's policy medication administration was requested but was not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven days (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for	01890		

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01890	Continued From page 24 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 not expired for one of three residents (R3) 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). Findings include: On September 28, 2021, at approximately 9:30 a.m., observed unlicensed personnel (ULP)-E administer medications to R3. R3's physician orders dated September 29, 2021, indicated R3's prescriptions included: acetaminophen 325 milligrams (mg) by mouth two times a day, amlodipine 2.5mg tab by mouth two times a day, memantine hcl 10 mg tablet by mouth two times a day, senna-s 8.6-50 mg tab by mouth two times a day, ibuprofen 600 mg tab by mouth three times daily as needed. On September 29, 2021, at approximately 10:00	01890		

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01890	Continued From page 25 a.m., the contents of R3's medication box was observed and revealed R3 had two bottles of ibuprofen 600 mg tablets, which were past the manufacturer's use by date of July 2021. On September 29, 2021, at approximately 4:40 p.m., director of nursing/registered nurse (DON/RN)-B stated all resident medications are labeled and the nurses check to ensure they are not expired. The licensee's policy for expired medication requested but was not provided. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32457	A. BUILDING: _____ B. WING _____	10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEMONT PLACE ALZHEIMER'S SPE	11748 ULYSSES LANE NE BLAINE, MN 55434

(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
01940	Continued From page 26 (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a treatment management plan to include all 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, 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). Findings include: R1 lacked a treatment and therapy management plan for blood sugar monitoring. R1's diagnoses included, but was not limited to Alzheimer's disease and renal failure.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32457	A. BUILDING: _____ B. WING _____	10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEMONT PLACE ALZHEIMER'S SPE	11748 ULYSSES LANE NE BLAINE, MN 55434

(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
01940	Continued From page 27 R1's prescriber's signed orders dated September 3, 2021, included blood sugar monitoring, "test 2 times/day. Reason: High A1C [blood test for type 2 diabetes and prediabetes]." R1's prescriber's unsigned orders dated September 16, 2021, included, "check blood glucose twice weekly." R1's Individualized Treatment and Therapy Management Plan, dated September 13, 2021, lacked a treatment and therapy plan for blood sugar monitoring. On September 29, 2021, at approximately 4:45 p.m., director of nursing/registered nurse (DON/RN)-B acknowledged R1's record lacked a treatment management plan and that she will work to update the record. The licensee's treatment and therapy management plan policy requested but not provided. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
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	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32457	A. BUILDING: _____ B. WING _____	10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEMONT PLACE ALZHEIMER'S SPE	11748 ULYSSES LANE NE BLAINE, MN 55434

(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
02040	Continued From page 28 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: Based on record review and interview, the licensee failed to perform a hazard vulnerability or safety risk assessment around the licensee's property to protect the residents from potential harm. This had the potential to directly affect all 41 residents and staff. 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: On September 28, 2021, at 11:00 a.m., survey staff conducted document review of the licensee's hazard vulnerability or safety risk assessment plans with licensed assisted living director (LALD)-A. LALD-A indicated that the plan was outdated and was being updated to be a facility-specific plan. The document identified many potential hazards and vulnerability assessments such as blizzards, tornadoes, epidemic, fire alarm failure, HVAC failure, etc., however, the documentation lacked a mitigation plan to each risk to ensure protection and effectively respond to all potential hazards that could directly affect all memory care residents, and therefore was incomplete. Specific prevention measures to mitigate risk from the	02040		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	32457	A. BUILDING: _____ B. WING _____	10/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDGEMONT PLACE ALZHEIMER'S SPE	11748 ULYSSES LANE NE BLAINE, MN 55434

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02040	Continued From page 29 identified potential hazard and vulnerability assessment must be developed and documented in the plan for all emergency situations. On September 28, 2021, at approximately 11:30 a.m., LALD-A confirmed all potential hazards would be assessed and mitigated to protect the residents from harm and would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		

Minnesota Department of Health
Division of Environmental Health, FPLS
625 Robert St. N.
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *09/27/21*
Time: 09:45:00
Report: 1022211208

Food and Beverage Establishment Inspection Report

Location:
Edgemont Place
11748 Ulysses Ln NE
Blaine, MN55434
Anoka County, 02

Establishment Info:
ID #: N000HRD
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 763-862-7000
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.

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

OBSERVED PINK SLIME ON THE BAFFLE OF THE ICE MACHINE. CLEAN SLIME WITH APPROVED SANTIZER.

Comply By: 09/27/21

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

3-305.11A

MN Rule 4626.0300A Store all food in a clean, dry location; where it is not exposed to splash, dust or other contamination; and at least 6 inches above the floor.

OBSERVED BOXES OF BUNS ON THE FLOOR IN THE WALK IN COOLER. USE RACKS/EQUIPMENT THAT ALLOWS FOR REGULAR FLOOR CLEANING.

Comply By: 09/27/21

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

OBSERVED A STEAM WELL AT THE STEAM TABLE IN DISREPAIR. PIC STATED THAT A WORK ORDER HAS BEEN PLACED.

Comply By: 09/27/21

4-900 Protecting Clean Items

4-903.11A

MN Rule 4626.0955A Store all clean equipment, utensils, linens, single-service and single-use articles in a clean dry location where not exposed to splash, dust, or other contamination and at least six inches above the floor.

OBSERVED BOXES OF DINNER NAPKINS ON THE FLOOR IN THE DRY STORAGE AREA.

Comply By: 09/27/21

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

OBSERVED A LEAKY FAUCET AT THE SPRAY SINK IN THE DISHWASHING AREA.

Comply By: 09/27/21

Surface and Equipment Sanitizers

Dishmachine surface level: = at 165.7 Degrees Fahrenheit
Location: High temperature dishmachine
Violation Issued: No

Quaternary Ammonia: = 400 ppm at Degrees Fahrenheit
Location: Three compartment sink dispenser
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Walk-In Cooler
Temperature: 38 Degrees Fahrenheit - Location: Shredded cheddar cheese
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 40 Degrees Fahrenheit - Location: Heavy whipping cream
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	1	4

1. Establishment uses all pasteurized foods and all cooked foods are cooked to a temperature of 165°F prior to serving.
2. Establishment uses tablets called BruTab6S for sanitization and disinfection of vomit/diarrhea in food service areas. This product is approved to disinfect for Norovirus.

Food and Beverage Establishment Inspection 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 1022211208 of 09/27/21.

Certified Food Protection Manager: Tana R. Fry

Certification Number: FM102632 Expires: 10/24/22

Inspection report reviewed with person in charge and emailed.

Signed: _____

Tana Fry
Culinary Fry

Signed: _____

Inspector Number 1022

651-201-4500
health.foodlodging@state.mn.us

Report #: 1022211208

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Division of Environmental Health, FPLS
625 Robert St. N.
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	1	**Date**	09/27/21
No. of Repeat RF/PHI Categories Out	0	**Time In**	09:45:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

	Address	**City/State**	**Zip Code**	**Telephone**
Edgemont Place	11748 Ulysses Ln NE	Blaine, MN	55434	763-862-7000

License/Permit #	**Permit Holder**	**Purpose of Inspection**	**Est Type**	**Risk Category**
N000HRD		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44	X	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	X	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:** 09/27/21

Inspector (Signature)