Electronically Delivered

June 2, 2023

Licensee
Friendship Court
1228 South Rice Street
Blue Earth, MN 56013

RE: Project Number(s) SL30633015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 18, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

the specific statute(s).

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

A state correction 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for 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

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

If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30633	A. BUILDING: _____ B. WING _____	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP COURT	1228 SOUTH RICE STREET BLUE EARTH, MN 56013

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30633015-0 On May 15, 2023, through May 18, 2023, 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 25 active residents; 19 receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (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 staffing schedule was posted as required, potentially affecting the licensee's current residents and any 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	0 470		

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0 470	Continued From page 2 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 a daily staffing schedule developed by the clinical nurse supervisor to: - include direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; - identify the direct-care staff member's resident assignments or work location; and - be posted after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On May 15, 2023, at 11:15 a.m. during the facility tour with licensed assisted living director (LALD)-A, the surveyor observed the main entry area and resident common areas of the building. There was no staff schedule observed. LALD-A stated the daily schedule was posted in the nurse's office for staff to view but was not accessible to residents, volunteers, or visitors. 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: (B) food must be prepared and served according	0 480		

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0 480	Continued From page 3 to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 15, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents;	0 680		

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0 680	Continued From page 4 (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post an emergency preparedness plan prominently. This had the potential to impact all residents, staff, and visitors to the licensee's facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On May 15, 2023, at 11:15 a.m. during the facility tour with licensed assisted living director (LALD)-A, the surveyor did not observe any signage or information regarding the licensee's emergency disaster or preparedness plan posted. At this time, LALD-A stated the plan was not	0 680		

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0 680	Continued From page 5 posted prominently and was not aware of the requirement. The licensee's 9.02 Disaster Planning and Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with Centers for Medicare and Medicaid Service (CMS) Appendix Z. No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous	0 730		

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0 730	Continued From page 6 assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included a discharge summary with the required content for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	0 730		

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0 730	Continued From page 7 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included dementia. R1 began receiving services on June 15, 2019, and was discharged on May 1, 2023. R1's record lacked a discharge summary to include: - diagnoses; - course of illness; - allergies; - treatments and therapies; - pertinent lab, radiology, and consultation results; and - a final summary of the resident's status from the latest assessment or review including baseline and current mental, behavioral, and functional status; - a reconciliation of all predischarge medications with the resident's post-discharge prescribed and over-the -counter medications; and - a post-discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post-discharge plan must indicate where the resident plans to reside, any arrangement that have been made for the resident's follow-up care, and any post-discharge medical and nonmedical services the resident will need. On May 15, 2023, at 3:23 p.m. clinical nurse supervisor (CNS)-B stated there was a discharge summary form to complete, but it was "missed" and not completed when R1 discharged.	0 730		

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0 730	Continued From page 8 The licensee's 2.38 Resident Record - Information and Content policy dated August 1, 2021, noted resident records must include: 14. A discharge summary, including service termination notice and related documentation, when applicable. The licensee's 1.15 Contract Termination policy dated August 1, 2021, included: 7. Resident discharge summary: at the time of discharge, [The Licensee] would provide the resident, and, with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that includes: -a summary of the residents stay that includes diagnoses, courses of illnesses, allergies, treatments, and therapies, and pertinent lab, radiology, and consultation results; -a final summary of the resident status from the latest assessment or review, if applicable, which includes the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischarge medications with the resident's post-discharge prescribed and over-the-counter medications; and -a post-discharge care plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post-discharge care plan will indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post-discharge medical and nonmedical services the resident will need. No further information was provided. TIME PERIOD FOR CORRECTIONS:	0 730		

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0 730	Continued From page 9 Twenty-one (21) days	0 730		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. This deficient condition had the potential to affect all staff, residents, and visitors.	0 780		

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0 780	Continued From page 10 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). Findings include: On May 17, 2023, between 12:45 p.m. and 1:45 p.m., survey staff toured the facility with the director of maintenance (DM)-D and maintenance (M)-E. During the facility tour, survey staff observed that the smoke alarms did not sound as interconnected when tested in dwelling units 111, 112, 203, and 215. This deficient condition was verified by DM-D and M-E accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.	01290		

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01290	Continued From page 11 (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for one of three employees (unlicensed personnel (ULP)-C). 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-C was hired on June 24, 2022, and started providing direct care and services to the licensee's residents under the assisted living license. On May 16, 2023, at 7:20 a.m. the surveyor observed ULP-C administer medications to R2. ULP-C's employee record contained a background study dated October 6, 2018, for a separate location operated by the licensee's owner. ULP-C's employee record further contained a background study clearance letter dated May 16, 2023. ULP-C's employee record	01290		

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01290	Continued From page 12 lacked evidence the licensee affiliated a background study for their license until after the survey process began and ULP-C's file was requested for review. On May 18, 2023, at 9:00 a.m. licensed assisted living director (LALD)-A stated ULP-C's background study had not been affiliated with the assisted living facility license until the file was requested for review. The licensee's 4.02 Background Studies policy dated August 1, 2021, indicated a Minnesota Department of Human Services Background Study would be done on all employees, volunteers, and contractors of [The Licensee]. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must	01620		

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be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, not to exceed 90 calendar days from the last date of the assessment for two of two residents (R3, R2).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R3
R3's Addedum [sic] A (identified as the most recent revised service plan) dated October 5, 2022, indicated R3 received services including medication administration, TED (thrombo-embolic deterrent) stockings (compression socks used to increase circulation to prevent swelling), and

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01620	Continued From page 14 weights. On May 17, 2023, R3's record indicated the last assessment by the RN was completed on February 9, 2023, (97 calendar days thus far) exceeding the required 90 calendar days. R2 R2's Addedum [sic] A (identified as the most recent revised service plan) dated May 24, 2022, indicated R2 received services including medication administration, shower assistance, and Compreflex velcro wraps (inelastic compression system for the foot and calf) to bilateral lower legs. R2's last two assessments were requested. Assessments dated November 30, 2022, and March 1, 2023, were provided. The March 1, 2023, assessment was 91 days from the date of the previous assessment, exceeding 90 calendar days. On May 17, 2023, at 9:30 a.m. clinical nurse supervisor (CNS)-B stated R3 and R2's most recent assessments exceeded 90 calendar days. CNS-B stated she used a calendar system for tracking but "missed" R3's assessment and did not count actual days for tracking indicating the reason R2's assessment was late. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated January 30, 2022, included ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. No further information was provided.	01620		

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01620	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01640		

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01640	Continued From page 16	01640		

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:

R3's diagnosis included weakness.

R3's Addedum [sic] A (identified as the most recent revised service plan) dated October 5, 2022, indicated R3 received services including medication administration, TED (thrombo-embolic deterrent) stockings (compression socks used to increase circulation to prevent swelling), and weights.

R3's Individualized Treatment or Therapy Management Plan dated August 23, 2022, included weight monitoring with instructions to refer to the prescriber order for specifics.

R3's progress note dated November 11, 2022, read resident did not want daily weights checked anymore, weights stable. A signed prescriber telephone order dated November 11, 2022, identified to discontinue daily weight at resident request.

On May 16, 2023, at 7:05 a.m. unlicensed personnel (ULP)-C stated R3 no longer had daily weights.

On May 17, 2023, at 2:35 p.m. clinical nurse supervisor (CNS)-B stated R3's daily weights were discontinued on November 22, 2022, per resident request and prescriber order. CNS-B

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01640	Continued From page 17 stated R3's service agreement should have been updated at that time, but it was not. The licensee's 6.10 Service Plan Modifications policy dated January 30, 2022, identified when a change to the service plan occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure delegated procedures were followed for one of three residents (R4) observed during medication administration. In addition, the licensee failed to document the site of injection for one of one	01750		

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resident (R4).

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:

R4's diagnoses included diabetes (disease that affects how the body uses blood sugar), anxiety (sense of uneasiness), age-related cognitive decline (decline in memory and thinking that happens with age).

R4's Addedum [sic] A (identified as the most recent revised service plan) dated March 1, 2022, indicated R4 received services including, medication administration, blood sugar checks, and verifying insulin dosage.

R4's signed physician orders dated April 13, 2022, included an order for Lantus (long-acting) insulin inject 16 units subcutaneous (under the skin) one time a day.

R4's medication administration record (MAR) for May 2023, included the order for Lantus insulin 16 units subcutaneous once a day. The medication sheet included a spot for each date and staff initials to indicate the medication had been administered. However, it lacked a space to indicate the site the insulin was administered on the resident's body.

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01750	Continued From page 19 On May 16, 2023, at 7:36 a.m. the surveyor observed unlicensed personnel (ULP)-C preparing R4's Lantus SoloStar insulin pen for administration. ULP-C removed the cap, obtained an alcohol wipe, and swabbed the end of the insulin pen prior to applying the needle. Once the needle was applied to the pen, ULP-C handed the insulin pen to R4 and he turned the dial to 16 units, had ULP-C verify the pen was set at 16 units, then cleansed skin on his upper left arm and injected the prescribed dosage. ULP-C did not prime the insulin pen with two units to remove any air prior to handing the insulin pen to R4, nor did ULP-C prompt R4 to prime insulin pen prior to dialing the dosage. When interviewed following R4's insulin administration, ULP-C stated she had not primed R4's insulin pen and should have. ULP-C then returned to the medication cart to document the Lantus administration; however, no location was documented. ULP-C stated there was not an area for her to document this and would need to notify the nurse to add a location. ULP-C added she had been trained to prime the insulin pen with two units or prompt the resident to prior to dialing up the dosage and to document the location of an insulin administration by the previous registered nurse (RN). On May 16, 2023, at 9:22 a.m. clinical nurse supervisor (CNS)-B stated insulin should be administered according to the manufacturer's recommendations. CNS-B stated ULP-C should have primed the insulin pen or prompted R4 to do so. CNS-B further stated the location of insulin injections should be documented and she would need to update R4's medication administration record (MAR) to include this information. Lantus SoloStar pen manufacturer instructions dated August 2022, included:	01750		

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01750	Continued From page 20 Step 3 Perform a Safety Test - dial a test dose of 2 units; - hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needled. This will help you get the most accurate dose; -press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go back to zero after you perform the test; -if no insulin comes out, repeat the test two more times. If there is still no insulin coming out, use a new needle and do the safety test again. Choose an Injection Site -rotate your injection site with each dose to reduce your risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. Do not use the same spot for each injection. The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated January 31, 2022, noted when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [The Licensee] would ensure that the registered nurse has instructed the ULP in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures. Specified in writing, specific instructions for each resident and documented those instructions in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

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01760 SS=E	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, interview, and record review, the licensee failed to ensure prescribed medications were clarified with dosage for one of three residents (R2). In addition, the licensee failed to ensure prescribed medications were transcribed as ordered for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01760		

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01760	Continued From page 22 R2 R2's diagnoses included weakness, dysuria (painful urination), and urinary tract infections. R2's Addedum [sic] A (identified as the most recent revised service plan) dated May 24, 2022, indicated R2 received services including medication administration. R2's Medication Administration Record (MAR) dated May 2023, included cranberry extract (prevents urinary tract infections) capsule 425 milligrams (mg) two (2) capsules by mouth (po) twice daily (BID). On May 16, 2023, at 7:20 a.m. unlicensed personnel (ULP)-C administered cranberry extract capsules 400 mg two tabs to R2. ULP-C stated the order did not match the medication bottle and indicated she would have to tell the nurse. ULP-C further stated she could administer the medication since the dose would be less than what the physician had ordered, and proceeded to administer to R2. R2's record contained signed prescriber orders dated February 27, 2023. The orders identified: cranberry supplement AM and PM. The physician order lacked a dosage to administer. The order was signed "noted" by clinical nurse supervisor (CNS)-B. On May 16, 2023, at 9:22 a.m. CNS-B stated the cranberry extract administered needs to match the cranberry extract order on medication administration record (MAR) and physician order. CNS-B stated the cranberry extract dosage on MAR was different from R2's medication bottle indicating R2 had received the wrong dosage and	01760		

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01760	Continued From page 23 would need to clarify dosage order with the physician. On May 16, 2023, at 1:25 p.m. CNS-B stated R2 was lacking a complete signed prescriber order for the cranberry supplement as required, and indicated the order should have been clarified with the physician. CNS-B further stated she must have written the order in R2's MAR with the medication dosage recommended on the original bottle of cranberry extract the family had brought in. TRANSCRIPTION ERROR R3 R3's diagnosis included weakness. R3's Addedum [sic] A (identified as the most recent revised service plan) dated October 5, 2022, indicated R3 received services including medication administration, TED (thrombo-embolic deterrent) stockings (compression socks used to increase circulation to prevent swelling), and weights. R3's prescriber's orders dated March 3, 2023, included artificial tears 1.4% solution place one drop into both eyes twice daily. R3's MAR included artificial tears one drop twice a day. The MAR failed to include which eyes the artificial tear was to be administered. On May 16, 2023, at 8:20 a.m. the surveyor observed ULP-C obtain and prepare R3's scheduled medications and artificial tears from the medication cart. ULP-C went to R3's room, administered the oral medications, sanitized hands, applied gloves, and administered the artificial tears one drop to each eye. ULP-C	01760		

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01760	Continued From page 24 removed gloves, sanitized hands, and returned to medication cart to document administration. When interviewed at this time, ULP-C stated R3's MAR identified the artificial tears one drop but did not identify which eyes the eye drop should be administered to. ULP-C further stated she administered one drop to both eyes indicating that is what R3 preferred. On May 16, 2023, at 9:22 a.m. CNS-B stated R3's eye drops were suppose to be one drop each eye per physician orders and it must have been transcribed incorrectly onto the MAR. The licensee's 7.17 Medication & Treatment Orders - Receiving policy dated January 31, 2022, included: 2. Content of medication orders must contain the name of the drug, dosage, frequency, route, indication and directions for use. The licensee's 7.20 Medication & Treatment Orders policy dated January 31, 2022, included a current written prescriber's order must be obtained for any treatment or medication administration provided to a resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.	01820		

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01820	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider had managed for one of three residents (R2). 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: R2's record lacked signed prescriber orders for a medication administered by the licensee. R2's diagnoses included weakness, dysuria (painful urination), and urinary tract infections. R2's Addedum [sic] A (identified as the most recent revised service plan) dated May 24, 2022, indicated R2 received services including medication administration, shower assistance, and compreflex velcro wraps (inelastic compression device) to bilateral lower legs. R2's Medication Administration Record (MAR) dated May 2023, included cranberry extract (prevents urinary tract infections) capsule 425 milligrams (mg) two (2) capsules by mouth (po) twice daily (BID).	01820		

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FRIENDSHIP COURT	1228 SOUTH RICE STREET BLUE EARTH, MN 56013

(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
01820	Continued From page 26 On May 16, 2023, at 7:20 a.m. unlicensed personnel (ULP)-C administered cranberry extract capsules 400 mg two tabs to R2. ULP-C stated the order did not match the medication bottle and indicated she would have to tell the nurse. ULP-C further stated she could administer the medication since the dose would be less than what the physician had ordered. R2's record contained signed prescriber orders dated February 27, 2023. The orders identified: cranberry supplement AM and PM. The physician order lacked a dosage to administer. The order was signed "noted" by clinical nurse supervisor (CNS)-B. On May 16, 2023, at 1:25 p.m. CNS-B stated R2 was lacking a complete signed prescriber order for the cranberry supplement as required and indicated the order should have been clarified with the physician. CNS-B further stated she must have written the order in R2's MAR with the medication dosage recommended on the original bottle of cranberry extract the family had brought in. The licensee's 7.17 Medication & Treatment Orders - Receiving policy dated January 31, 2022, included: 2. Content of medication orders must contain the name of the drug, dosage, frequency, route, indication and directions for use. The licensee's 7.20 Medication & Treatment Orders policy dated January 31, 2022, included a current written prescriber's order must be obtained for any treatment or medication administration provided to a resident. No further information was provided.	01820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30633	A. BUILDING: _____ B. WING _____	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP COURT	1228 SOUTH RICE STREET BLUE EARTH, MN 56013

(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
01820	Continued From page 27 TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to renew prescriptions at least every 12 months for one of three residents (R4). 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: R4's record lacked an annual renewal of prescriber orders for medications. R4's diagnoses included diabetes (disease that affects how the body uses blood sugar), anxiety (sense of uneasiness), age-related cognitive decline (decline in memory and thinking that happens with age).	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30633	A. BUILDING: _____ B. WING _____	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP COURT	1228 SOUTH RICE STREET BLUE EARTH, MN 56013

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01830	Continued From page 28 R4's Addedum [sic] A (identified as the most recent revised service plan) dated March 1, 2022, indicated R4 received services including lab draws by facility registered nurse (RN), medication administration, blood sugar checks, verifying insulin dosage, and weights. On May 16, 2023, at 7:36 a.m. the surveyor observed unlicensed personnel (ULP)-C administer eye drops and verify an insulin dosage for R4 in his apartment. R4's Medication Administration Record (MAR), dated May 2023, included the following medications: - artificial tears (lubricating eye drop) one drop both eyes four times per day; -Lantus (long acting) insulin 16 units subcutaneous once daily. R4's most current prescriber orders, dated April 13, 2022, included the above medications; however, it was 35 days past the annual renewal date requirement. On May 17, 2023, at 3:50 p.m. clinical nurse supervisor (CNS)-B stated R4's prescriber orders had not been updated at least annually as required. CNS-B further indicated she was not aware of this requirement. The licensee's 7.18 Medication & Treatment Orders - Renewal policy, dated January 31, 2022, indicated medication and treatment orders would be renewed at least every 12 months or more frequently as required. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30633	A. BUILDING: _____ B. WING _____	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP COURT	1228 SOUTH RICE STREET BLUE EARTH, MN 56013

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01830	Continued From page 29 days	01830		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. 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 the medication, for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30633	A. BUILDING: _____ B. WING _____	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP COURT	1228 SOUTH RICE STREET BLUE EARTH, MN 56013

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01910	Continued From page 30 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: R1's Addedum [sic] A (identified as the most recent revised service plan) dated August 17, 2022, indicated R1 received services including medication management. R1 was discharged to a skilled nursing facility on May 1, 2023. R1's record lacked 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. On May 15, 2023, at 3:23 p.m. clinical nurse supervisor (CNS)-B stated she sent all of R1's medications to the skilled nursing facility upon R1's discharge. However, CNS-B stated she did not document the disposition of medications to include the above required components. The licensee's 7.23 Medication Disposal policy dated January 31, 2022, noted 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. No further information was provided.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30633	A. BUILDING: _____ B. WING _____	05/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP COURT	**1228 SOUTH RICE STREET BLUE EARTH, MN 56013**

(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 31 TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

DEPARTMENT OF HEALTH

Type: Full
Date: *05/15/23*
Time: 12:00:00
Report: 1033231072

Food and Beverage Establishment Inspection Report

Location:
Friendship Court
1228 South Rice Street
Blue Earth, MN56013
Faribault County, 22

Establishment Info:
ID #: 0038205
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5075266351
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.

4-500 Equipment Maintenance and Operation

4-501.114E ** Priority 1 **

MN Rule 4626.0805E Provide and maintain a chemical sanitizer other than chlorine, iodine or a quaternary ammonium compound according to the US EPA registered label use instructions.

Spray bottle of lactic acid sanitizer was measured at 0PPM.

Comply By: 05/15/23

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

Facility does not have a small diameter probe.

Comply By: 05/29/23

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

Facility does not have a measuring device to measure the utensil surface temperature.

Comply By: 05/29/23

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Employees do not have a test kit to measure the sanitizing concentration.

Corrected on Site

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

Facility has a household refrigerator in the kitchen.

Comply By: 05/15/23

Surface and Equipment Sanitizers

Acid: = 0PPM at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: Yes

Acid: = 1875PPM at Degrees Fahrenheit
Location: Spray Bottle
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: Dish Machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 0> Degrees Fahrenheit - Location: Freezer
Violation Issued: No

Process/Item: Hot Holding
Temperature: 170 Degrees Fahrenheit - Location: Mashed Potatoes-Hot Line
Violation Issued: No

Process/Item: Hot Holding
Temperature: 165 Degrees Fahrenheit - Location: Pork Chops-Hot Line
Violation Issued: No

Process/Item: Cold Holding
Temperature: Degrees Fahrenheit - Location:
Violation Issued: Yes

Type: Full
Date: *05/15/23*
Time: 12:00:00
Report: 1033231072
Friendship Court

Food and Beverage Establishment Inspection Report

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

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 1033231072 of 05/15/23.

Certified Food Protection Manager: Reane A Hoeper

Certification Number: FM108705 Expires: 08/31/24

Inspection report reviewed with person in charge and emailed.

Signed: _____
Reane A Hoeper

Signed: _____
Isaiah Armendariz
Environmental Health Specialist
Mankato District Office
507-344-2743
isaiah.armendariz@state.mn.us

Report #: 1033231072

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

No. of RF/PHI Categories Out	1	Date	05/15/23
No. of Repeat RF/PHI Categories Out	0	Time In	12:00:00
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Friendship Court	1228 South Rice Street	Blue Earth, MN	56013	5075266351

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038205		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	X	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	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 05/18/23

Inspector (Signature)