Electronically Delivered

January 26, 2024

Licensee
Nouis Home Care Incorporated
308 1st Street Southeast
Little Falls, MN 56345

RE: Project Number(s) SL28501015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 4, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines 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 MDH within 15 calendar days of the correction order receipt date.

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

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28501	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOUIS HOME CARE INCORPORATED	308 1ST STREET SE LITTLE FALLS, MN 56345

(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: SL28501015-0 On January 2, 2024, through January 4, 2024, 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 36 active residents whom were receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety	0 640		

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0 640	Continued From page 1 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 information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and the 911 emergency number in common areas and near telephones provided by the facility as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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: During a tour of the facility with licensed assisted living director (LALD)-A on January 2, 2024, at 10:30 a.m., the surveyor observed several bulletin boards and a resident phone booth located in the	0 640		

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0 640	Continued From page 2 main area of the facility; however, none of the required Minnesota Adult Abuse Reporting Center (MAARC) contact information or 911 emergency number was posted. On January 2, 2024, at 12:36 p.m., LALD-A stated he thought MAARC information was posted somewhere on the board, however, he was unable to locate the required information. LALD-A stated the phone booth located in the main hallway was called the "resident phone booth" used by all residents and stated he was unaware of the requirement to have the 911 emergency number posted near the telephone. The licensee's Maltreatment, Communication, Prevention, and Reporting policy dated July 22, 2021, did not address the MAARC or 911 posting requirements. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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;	0 780		

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0 780	Continued From page 3 (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 functioned and interconnected so the actuation of one alarm causes all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On January 4, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour survey staff observed the following:	0 780		

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0 780	Continued From page 4 1. The smoke alarms in Apartment 7 were not interconnected. 2. The smoke alarm in Apartment 201B did not sound when the test button was pushed. 3. There was no smoke alarm outside and in the immediate vicinity of the sleeping area in Apartment 210. During interview on January 4, 2024, at 10:30 a.m, LALD-A stated he thought they had checked all the smoke alarms in the past year, but thought some of the residents may have tampered with their smoke alarms. He stated he understood the deficiencies and would have his maintenance staff check all the apartments again. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 790		

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0 790	Continued From page 5 failed to maintain fire extinguishers in accordance with MN Statute. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 4, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. It was observed the portable fire extinguishers were tagged showing the required annual service date but lacked the records to show the required monthly visual inspections to date. During interview on January 4, 2024, at 10:30 a.m., survey staff explained to LALD-A the portable fire extinguishers must be provided annual certification tags and also monthly visual inspection or "quick checks" of each extinguisher by a staff member to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD-A verified the findings and stated that he understood the requirements. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		

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0 800	Continued From page 6	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 4, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-A. It was observed in Apartment 101 unused wires of an old smoke alarm system	0 800		

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0 800	Continued From page 7 were exposed to the room just above the resident's bed and above the bathroom door. The wires had industry-standard caps on them, but they were within reach of anyone in the room. It was observed in Apartment 101 there was a hole in the wall adjacent to the closet. The hole exposed the inside of the wall to the bedroom. LALD-A stated the hole looked like it was from an old plumbing line or pipe that had not been patched after the pipe was removed. It was observed in Apartment 213 there were missing tiles around the bathroom vanity. The missing tiles exposed the wall substrate to water penetration and potential mold growth. LALD-A stated the vanity had been replaced in the bathroom but the tiles around it had not been modified yet. It was observed outside of Apartment 209, inside the electrical cabinet, the metal fire-rated box had been damaged and parts of it were pulled away exposing the inside of the wall shaft to the electrical panel. LALD-A stated they recently had electrical work done after an inspection by the fire marshal and had not been back through the building to finish up the repairs around the areas that had work. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:	0 810		

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0 810	Continued From page 8 (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 9 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 4, 2024, licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "7.04 Fire", dated July 26, 2021, and "7.05 Fire", dated February 1, 2020, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policies had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which had an automatic fire sprinkler system and smoke detection system but did not have an automatic dialer on the smoke detection system, did not have fire doors on magnetic hold opens, and did not have smoke compartments.	0 810		

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0 810	Continued From page 10 The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on January 4, 2024, at 1:00 p.m., LALD-A stated he understood the areas of his policy that were incomplete and would work on bringing them into compliance. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-A was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A was unable to provide documentation showing any training provided or training scheduled for a future date for staff since the date of the last survey. During an interview on January 4, 2024, at 1:00 p.m., LALD-A stated staff was assigned training	0 810		

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0 810	Continued From page 11 on a third-party web-based platform that covered basic fire safety principles but was not specific to the facility plan and procedures. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Provided documentation indicated evacuation drills were completed on October 18, 2021, August 6, 2022, May 16, 2023, and October 27, 2023. During an interview on January 4, 2024, at 1:00 p.m., LALD-A stated he misunderstood the requirements laid out in statute but would ensure he complied going forward. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01470 SS=F	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 12 (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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	28501	A. BUILDING: _____ B. WING _____	01/04/2024

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01470	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of one 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 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: ULP-C was hired on March 1, 2014, under the comprehensive licensing and continued to provide direct care services under the assisted living license as of August 1, 2021. On January 3, 2024, at 10:02 a.m., the surveyor observed ULP-C provide wound care for R2. ULP-C's employee orientation record did not include an overview of the 144G statutes. On January 3, 2024, at 11:37 a.m., clinical nurse supervisor (CNS)-B and licensed assisted living director (LALD)-A reviewed ULP-C's employee training record with the surveyor. LALD-A stated ULP-C had not completed the assisted living orientation as required and it would not be found in the remaining ULP training files. LALD-A stated he thought he had assigned the correct module for staff to train on 144G statute,	01470		

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01470	Continued From page 14 however, 144G statute training was not assigned or completed by any ULP's. The licensee's Orientation policy dated January 1, 2016, noted upon hire and prior to performing any functions of their position at [licensee name] each new employee would be oriented in accordance with state and federal regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee	01530		

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01530	Continued From page 15 until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to provide employee dementia care training (at least eight hours within 120 working hours of the employment start date), on required topics for one of one supervisors of direct-care staff (clinical nurse supervisor (CNS)-B). 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: CNS-B was hired into the CNS role on September 21, 2023, to provide supervision and oversight to unlicensed personnel and to provide direct services to licensee's residents. On January 2, 2024, at 9:40 a.m., CNS-B stated she worked full-time, 40 hours a week or more supervising ULP's and provided nursing care for the licensee's residents. CNS-B's employee record lacked the required eight hours of dementia care training. CNS-B's record indicated five of the eight hours of dementia training required had been completed.	01530		

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01530	Continued From page 16 On January 3, 2024, at 10:50 a.m., CNS-B stated she had completed the dementia training modules assigned to her by licensed assisted living director (LALD)-A. LALD-A stated he thought the training modules assigned would meet the dementia training requirements. The licensee's Alzheimer's Disease and Related Disorders - Training and Notification policy dated July 22, 2021, did not address the required dementia training for supervisors of direct care staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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,	01910		

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	28501	A. BUILDING: _____ B. WING _____	01/04/2024

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01910	Continued From page 17 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 required content on disposition of the medications for one of one resident (R4) upon discharge. 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 was admitted on November 28, 2012, and discharged on November 21, 2023. R4's diagnosis included schizo-affective disorder. R4's prescriber orders dated February 25, 2023, did not include R4's prescribed hospice medications. R4's Discharge Summary note dated November 21, 2023, indicated R4 received medication management services from licensee to include hospice medications. R4's discharge summary note indicated R4's medications were destroyed by a hospice registered nurse (RN) and clinical nurse supervisor (CNS)-B.	01910		

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	28501	A. BUILDING: _____ B. WING _____	01/04/2024

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01910	Continued From page 18 On January 2, 2024, at 11:45 a.m., CNS-B requested a medication disposition from [hospice agency]. The hospice medication disposition included the following: - roxanol 20 milligram (mg)/ milliliter (ml) used for pain; - haldol 2 mg/ml for uncontrolled muscle movement; and - haldol 5 mg/ml for uncontrolled muscle movement. R4's discharge record lacked the required content to include the name, strength, prescription numbers of the medication, and quantity destroyed at time of discharge. R4's incomplete medication disposition dated December 1, 2023, included only medications managed by the licensee prior to the addition of hospice medications and included the following: - constulose 10 gram (G)/ 15 mg solution for constipation; - furosemide 40 mg for edema; - hyoscyamine sulfate used to treat intestinal discomfort; - spironolactone 10 mg for edema; and - tranexamic acid used to control bleeding. On January 2, 2024, at 11:21 a.m., CNS-B stated R4's record would not include hospice medications destroyed by the hospice RN and CNS-B. CNS-B stated she was unaware of the requirement to document and maintain a disposition record onsite for all medications destroyed by the licensee and had belonged to R4. The licensee's Disposal of Medications policy dated January 10, 2016, indicated upon	01910		

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01910	Continued From page 19 disposition of medications to include controlled substances, the license would document into the residents record the name, strength, prescription number of medications, as applicable, quantity, date of disposition, and names/signatures of staff involved in the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=E	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; (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	01940		

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01940	Continued From page 20 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 observation, interview, and record review, the licensee failed to develop an individual treatment management plan to include all required content for two of three residents (R2, 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: During the entrance conference on January 2, 2024, at 9:35 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment and therapy management services to the residents in the facility. R2 R2's diagnoses included major depressive disorder and diabetes type I. R2's service plan dated August 18, 2023, indicated R2 received services to include	01940		

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01940	Continued From page 21 compression stocking (TEDs), wound care and assistance with the application and removal of a right leg brace. R2's physician orders dated March 1, 2023, and December 11, 2023, respectively, indicated TEDs on for 12 hours, off for 12 hours as needed, wound care daily and brace application and removal daily. On January 3, 2024, at 10:02 a.m., the surveyor observed unlicensed personnel (ULP)-C enter R2's room and provide assistance with cleaning a right ankle wound measuring one centimeter (cm) in a circular diameter. ULP-C performed hand hygiene, applied gloves, removed old bandage, cleaned the wound, removed gloves, performed hand hygiene, reapplied gloves and applied a new bandage. ULP-C repeated the hand hygiene and glove process and applied a TED stocking to R2's right leg and completed the cares with application of a fitted ankle brace that laced from the top of the right foot to mid calf of R2's right leg. On January 3, 2024, at 10:02 a.m., R2 stated staff apply his TEDs and brace everyday and assist with removing every night. R3 R3's diagnoses included schizo-affective disorder and diabetes type II. R3's Service Recap Summary dated December 2023, indicated R3 received services to include TEDs daily. R3's physician orders dated June 1, 2023, prescribed TEDs to be on in the morning and removed at bedtime for the treatment of edema (excess fluid buildup in the lower extremities).	01940		

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01940	Continued From page 22 R2 and R3's Individual Treatment/Therapy Management Plan lacked the following content: - identification of the treatment or therapy that will be delegated to unlicensed personnel; - procedures for notifying a nurse or appropriate licensed health professional when a problem arises with the treatments or therapy services; and - any resident-specific requirements relating to documenting 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. On January 4, 2024, at 9:40 a.m., clinical nurse supervisor (CNS)-B confirmed R2 and R3's record lacked a complete and accurate individualized treatment and therapy plan. CNS-B stated she was unaware all treatments were required to be included in an individualized treatment and therapy plan. The licensee's Medications and Treatments policy dated August 2021, indicated when the licensee managed treatment or therapy services for the resident, the facility would develop and maintain a current individualized treatment and therapy management record to include a statement of the type of service, documentation of specific resident instructions, identification of the treatment to be delegated to unlicensed personnel, identification of the procedure for notifying the registered nurse and any resident-specific requirements relating to documentation of the treatment received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	01940		

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01940	Continued From page 23 days	01940		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident 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 record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific treatment instructions for each resident, and documented those instructions in the resident record for two of three residents (R2, 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	01950		

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01950	Continued From page 24 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2's diagnoses included major depressive disorder and diabetes type I. R2's service plan dated August 18, 2023, indicated R2 received treatments to include compression stocking (TEDs), wound care and assistance with the application and removal of a right leg brace. R2's physician orders dated March 1, 2023, and December 11, 2023, respectively, indicated TEDs on for 12 hours, off for 12 hours as needed, wound care daily and brace application and removal daily. On January 3, 2024, at 10:02 a.m., the surveyor observed unlicensed personnel (ULP)-C enter R2's room and provide assistance with cleaning a right ankle wound measuring one centimeter (cm) in a circular diameter. ULP-C performed hand hygiene, applied gloves, removed old bandage, cleaned the wound, removed gloves, performed hand hygiene, reapplied gloves and applied a new bandage. ULP-C repeated the hand hygiene and glove process and applied a TED stocking to R2's right leg and completed the cares with application of a fitted ankle brace that laced from the top of the right foot to mid calf of R2's right leg. On January 3, 2024, at 10:02 a.m., R2 stated staff apply his TEDs and brace everyday and assist with removing every night.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 25 R3 R3's diagnoses included schizo-affective disorder and diabetes type II. R3's Service Recap Summary dated December 2023, indicated R3 received services to include TEDs daily. R3's physician orders dated June 1, 2023, prescribed TEDs to be on in the morning and removed at bedtime for the treatment of edema (excess fluid buildup in the lower extremities). On January 4, 2024, at 9:40 a.m., clinical nurse supervisor (CNS)-B confirmed R2 and R3's record lacked specific registered nurse (RN) treatment instructions, in writing, and documentation of those instructions for R2 and R3's record. CNS-B stated she had been working through the residents documents since she had been hired in September 2023 to update documents as needed, however, may not have gotten to R2 and R3's documents yet. The licensee's Medication and Treatment policy dated August 2021, indicated the RN may delegate to unlicensed personnel the task of providing assistance with treatments if the RN identified resident specific instructions for documenting treatment administration verification. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02290	Continued From page 26	02290		
02290 SS=F	144G.91 Subd. 2 Legislative intent The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee included within the residency agreement contract language which limited the rights of three of three residents (R1, R2, R3). This had the potential to affect all residents and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: R1, R2 and R3's assisted living contracts signed and dated respectively, August 11, 2023, included an attachment titled "Rules of the Home and Other Info". The Rules of the Home document included 18 bulleted items that residents were required to follow in order to remain a resident of licensee's facility and included: - no alcohol is allowed on the premises, and you may not return to the home if you've been using drugs or alcohol; - borrowing, residents who loan money or buy	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28501	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOUIS HOME CARE INCORPORATED	308 1ST STREET SE LITTLE FALLS, MN 56345

(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
02290	Continued From page 27 and sell items to other residents do so at their own risk (you may not be paid back!!!). Recommendation: "Don't loan money"; - grooming, residents are asked to maintain a minimal level of personal grooming standards, bathing, shaving, combing and clean clothes; - pharmacy services [licensee name] utilizes the long term care pharmacy services provided by [pharmacy name]. Please send all prescriptions to this location so that we can achieve continuity of care; - if you schedule your own medical appointment without first speaking with a staff member we will not be able to gaurantee transportation; - if you commit a crime while a resident of [licensee name] you may lose your rental privileges. Each incident will be reviewed on a case-by-case basis; - I agree to a minimum of a 90-day stay from the date of arrival. I also agree to give 30 days written notice prior to departure; and - I have reviewed the above rules and agree to abide by them. I agree that violations of the "No Exception" rules can result in my immediate removal from the home. On January 2, 2024, at 12:53 p.m., clinical nurse supervisor (CNS)-B stated the Rules of the House document is signed by every resident and is a requirement to be signed as part of the admission process. On January 4, 2024, at 9:40 a.m., licensed assisted living director (LALD)-A stated the Rules of the House document assisted licensee to manage residents and maintain structure within the facility. LALD-A was unaware of regulation that provided guidance against limiting the rights of residents with the use of house rules.	02290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	28501	A. BUILDING: _____ B. WING _____	01/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOUIS HOME CARE INCORPORATED	308 1ST STREET SE LITTLE FALLS, MN 56345

(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
02290	Continued From page 28 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02290		

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164
651-201-4500

Type: Full
Date: *01/02/24*
Time: 11:40:32
Report: 1037241001

Food and Beverage Establishment Inspection Report

Location:
Nouis Home Care Incorporated
308 1st Street Se
Little Falls, MN56345
Morrison County, 49

Establishment Info:
ID #: 0038428
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3206323868
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200 at Degrees Fahrenheit
Location: 3 COMPARMENT SINK DISPENSER
Violation Issued: No

Chlorine: = 100 at Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 189 Degrees Fahrenheit - Location: CHILI
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: SLICED HAM
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK JUG
Violation Issued: No

Process/Item: Walk-In Cooler
Temperature: 39 Degrees Fahrenheit - Location: COTTAGE CHEESE
Violation Issued: No

Type: Full
Date: *01/02/24*
Time: 11:40:32
Report: 1037241001
Nouis Home Care Incorporated

Food and Beverage Establishment Inspection Report

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

DISCUSSED PROCEDURES WITH LEROY:
MAJORITY OF FOODS ARE COOKED TO SERVE.
SOME COOLING TAKES PLACE ONSITE. COOLING DISCUSSED WITH LEROY AND A FACT SHEET IS ATTACHED WITH REPORT. RECOMMENDED COOLING IN 2 HOTEL PANS WITH FOODS AT OR LESS THAN 2 INCHES THICK.
REHEATING TO 165 F.
HOT HOLDING AT OR ABOVE 135 DEG F AFTER REHEATED TO 165 DEG F.
THAWING ON TRAYS IN THE BOTTOM OF UPRIGHT COOLERS.
EGGS ARE COOKED HARD OR SCRAMBLED.
ALL DRESSINGS ARE PACKAGED, NO DRESSINGS MADE UP ONSITE.

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 1037241001 of 01/02/24.

Certified Food Protection Manager: LEROY NOUIS

Certification Number: 56190 Expires: 01/15/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
LEROY NOUIS

Signed: Michelle L Hovanes

Michelle Hovanes
Public Health Sanitarian
St. Cloud
320-223-7307
michelle.hovanes@state.mn.us

Report #: 1037241001

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging
PO Box 64975
St. Paul, MN 55164

No. of RF/PHI Categories Out	0
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 01/02/24
Time In 11:40:32
Time Out

Nouis Home Care Incorporated	Address: 308 1st Street Se	City/State: Little Falls, MN	Zip Code: 56345	Telephone: 3206323868
License/Permit #: 0038428	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

Compliance Status		COS	R
Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight	
2	IN OUT 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		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		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 01/02/24

Inspector (Signature) Michelle L Howes