Electronically Delivered

March 16, 2023

Licensee
Havenwood of Minnetonka
17710 Old Excelsior Boulevard
Minnetonka, MN 55345

RE: Project Number(s) SL34662015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 8, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

LICENSING ORDERS

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

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 evaluation of your facility**.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for

reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

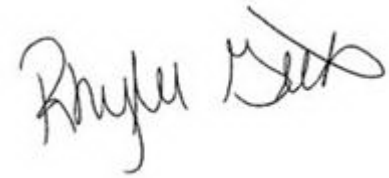
Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

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 this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Rhylee Gilb, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 218-232-8285 Fax:651-281-9796

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34662	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD OF MINNETONKA	17710 OLD EXCELSIOR BOULEVARD MINNETONKA, MN 55345

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #SL34662015 On February 6, 2023 through February 8 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 47 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance 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. 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. This had the potential to effect all residents. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). Findings include: Please refer to the Minnesota Food and Beverage Establishments Inspection Report, dated 02/06/2023. Time Period to Correct: Twenty-one (21) Days	0 480		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control	0 660		

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0 660	Continued From page 2 and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a two-step screening for active and latent TB for one of two unlicensed personnel (ULP)-A with personnel files reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected, or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: Review of ULP-A personnel file revealed ULP-A was hired on January 10, 2022. ULP-A's Baseline TB Screening Tool dated January 10, 2022, included documentation of a negative Mantoux tuberculin skin test (TST) on January 12, 2022,	0 660		

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0 660	Continued From page 3 although a second TST was not completed. On February 6, 2023, at approximately 1:00 p.m. Licensed Assisted Living Director (LALD)-D stated only a one step TB test was completed for ULP-A. LALD-D indicated a completed two step Mantoux test was the licensee's expectation, or a completed blood test could be used. The licensee's TB Prevention and Control policy dated February 2, 2022, indicated "prior to contact with residents, each staff person will be screened for TB. A two-step skin test or single interferon gamma release assay for tuberculosis will be administered." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents.	0 680		

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0 680	Continued From page 4 (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain the Emergency Preparedness Plan (EPP) program annually. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). Findings include: Review of EPP components, under the former ownership's name, indicated the last revision date was September 14, 2020. Review of EPP components, under the current ownership's name, indicated the last revision date was March 23, 2021. Review of a policy titled Emergency and Disaster Preparedness - Minnesota, dated February 10, 2022, indicated the emergency operations plan,	0 680		

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0 680	Continued From page 5 communication plan, and the policies and procedures listed will be reviewed and updated at least annually. An email, given to the MDH surveyor by licensed assisted living director (LALD)-B, dated February 6, 2023 at 1:55 p.m., indicated the licensee's Memorandum of Understanding (MOU)with a sister facility in Maple Grove had expired and they renewed the MOU through December 31, 2024. The Emergency/Disaster Plan policy, revision date May 22, 2019, indicated management will send out an updated emergency/disaster plan template yearly, during the month of February, for each community to modify/update their emergency plan. The executive director is responsible to ensure the plan is updated yearly and meets any specific local, county and state requirements. During an interview on February 7, 2023 at approximately 7:40 am LALD-D said the new management names should be on the EPP forms, not sure if they were all changed and updated. LALD-D said they need to review EPP annually. No further information provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days	0 680		
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;	0 790		

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0 790	Continued From page 6 (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 failed to maintain fire extinguishers in accordance with MN State Fire Code as required by MN Statute 144G.45 Subd.2 (a)(2). 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). Findings include: On February 7, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Assisted Living Director (LALD)-B and the Director of Maintenance (DM)-H. During the facility tour, it was observed that portable fire extinguishers were tagged, showing the required annual service but lacked records to	0 790		

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0 790	Continued From page 7 show the required monthly visual inspections were performed or recorded for all portable fire extinguishers throughout buildings. DM-H visually verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
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	0 800		

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0 800	Continued From page 8 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On February 7, 2023, at approximately 10:00 a.m., survey staff toured the facility with the Assisted Living Director (LALD)-B and the Director of Maintenance (DM)-H. During the facility tour, survey staff observed the following items: It was observed that the elevator lobby fire-rated door on the third floor did not close when it was tested. The door is required to close and positively latch when released from the hold-open magnet to maintain the fire integrity of the resident room and corridor for safety purposes. It was observed that the care suite fire door on the second floor had been disabled by removing the hold-open armature, and the door was propped open. Door magnets release the door from the open position in the event of a fire and allow it to close to protect the occupants and to contain the spread of fire. It was observed that the resident unit door in rooms 217D, 217 E, and 217A were propped open and had not closed automatically. The automatic door closer's were not installed, but spring hinges were installed at the door jamb. Additionally, the resident door 217D and 217E was propped open with rubber door wedge. The door is required to automatically close and latch to maintain the fire barrier from the corridor. It was observed that the exterior egress door at the outdoor space in the memory care was	0 800		

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0 800	Continued From page 9 obstructed by snow and was not maintained to keep an all-weather walk. The door was identified as an exit on the evacuation plans posted in the facility. It was observed that the burnt used cigarettes were being disposed of in a plastic bottle without a proper disposal container at outside of the exit door by the resident's storage on the garage level. It was observed that the fire safety and evacuation plans posted in the facility did not have locations and numbers of resident rooms. During the facility tour interview, DM-H visually verified these deficient findings at the time of discovery. 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: (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.	0 810		

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0 810	Continued From page 10 (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 record review and interview, the licensee failed to complete required employee evacuation drills every other month. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on	0 810		

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0 810	Continued From page 11 February 7, 2023, at approximately 10:00 a.m., with the Assisted Living Director (LALD)-B, and the Director of Maintenance (DM)-H on the fire safety and evacuation plan, fire safety and evacuation training, and fire safety and evacuation drills for the facility. A record review of the available documentation indicated that the licensee did not conduct evacuation drills twice per year per shift and every other month as required by statute. Provided documentation indicated that some drills were conducted for all shifts simultaneously and did not conduct during the shift-specific time. Record review indicated that the fire drills were conducted on 12/31/2022(2nd shift-9 am), 11/30/2022(1st shift- 9:00 am), 11/30/2022(2nd shift-9:00 am), 10/31/2022 (3rd shift-9:00 am), 7/31/2022(2nd shift-4:44 pm), 7/31/2022-10:10 pm), 6/30/2022 (1st shift-1:15 am), and 5/31/2022(1st shift-10:00 am) with no further drills being documented. And the facility failed to provide two drills during the second and third shifts. DM-H verified that there were no further documented drills for the facility and verified this deficient condition. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the	01060		

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(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
01060	Continued From page 12 facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the	01060		

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	34662	A. BUILDING: _____ B. WING _____	02/08/2023

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01060	Continued From page 13 required content for an emergency relocation to the resident, legal representative, or designated representative for one of one resident (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Findings include: Review of R2's medical record revealed R2 admitted to the licensee on February 24, 2020. R2's Progress Notes dated June 4, 2022, at 5:41 p.m., indicated R2 was transported to the emergency department due to falls. R2's After Visit Summary dated June 4, 2022, indicated R2 was seen at a hospital's emergency room for a fall and was discharged back to the care of the licensee at 4:17 a.m. the same day. R2's record lacked documentation that R2 or R2's designated representative received a written notice with all the required content for an emergency relocation. On February 8, 2023, at approximately 1:00 p.m., during the exit conference, licensed assisted living director (LALD)-D indicated R2 was not provided a written notice with required content for an emergency relocation, although licensee had developed a process for providing an emergency relocation notice, licensee had not implemented	01060		

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01060	Continued From page 14 the process for any resident who had an emergency relocation. The licensee's Contract Termination - Minnesota, dated February 10, 2022, indicated a written notice with the required content would be provided to the resident in the case of an emergency relocation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
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.	01640		

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01640	Continued From page 15 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included a signature or other authentication by the licensee and the resident or resident's designated representative to document agreement on the services to be provided for one of three residents (R5) records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: Review of R5's medical record revealed R5 was admitted on June 2, 2021. R5's Exhibit Service Plan Agreement signed July 21, 2021, was identified by licensed assisted living director (LALD)-D as R5's service plan. R5's Service Plan Agreement with effective date of February 7, 2023, was provided by LALD-D and indicated as the current service plan with the services R5 was receiving. The service plan included 25 identified services which were revised or added after the signed service plan dated July 21, 2021. On February 6, 2023, at approximately 1:00 p.m., LALD-D indicated R5's services had increased	01640		

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01640	Continued From page 16 and changed since R5 signed their service plan. LALD-D stated a current signed service plan with all services R5 received would not be in R5's record. The licensee's Contents of Service Plans - Minnesota dated February 10, 2022, indicated service plans and any revisions would include a signature or authentication by the licensee and resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;	01730		

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01730	Continued From page 17 (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain individualized medication management records that included all the required components for three of three residents (R1, R2 and R5) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). Findings include:	01730		

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01730	Continued From page 18 Review of R1's medical record revealed R1 was admitted to the licensee on December 5, 2022, with diagnoses including metabolic encephalopathy, hypertension and neuropathy. R1's Service Plan, dated December 5, 2022, indicated she received daily medication administration according to the electronic medication administration record (eMAR). R1's medication management assessment, dated December 13, 2022, was completed by registered nurse (RN)-F and indicated staff administered and managed all of R1's medications three times daily. R1's Uniform Assessment Tool, dated December 13, 2022, indicated R1 received medication management under Section 1D: "Yes, staff administers and manages all medications." R1's medication management record lacked descriptions of: - storage of medications and - identification of persons responsible for monitoring medication supplies and ensuring medication refills were ordered on a timely basis. Review of R2's medical record revealed R2 admitted to the licensee on February 24, 2020. R2's Uniform Assessment Tool dated January 10, 2023, and identified by licensed assisted living director (LALD)-D as R2's most recent registered nurse (RN) assessment, read under Medication Management, "D. Yes, staff administers and manages all medications." R2's Service Plan Agreement with effective date	01730		

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01730	Continued From page 19 of February 7, 2023, indicated R2 received medication management services and directed staff to "make sure R2's takes her meds. Do not leave them next to her as she is sitting in the chair." R2's medication management record lacked a description of: - identification of persons responsible for monitoring medication supplies and ensuring medication refills were ordered on a timely basis. Review of R5's medical record revealed R5 was admitted to the licensee on June 2, 2021, with diagnoses including Parkinson's disease and bilateral absolute glaucoma. R5's service plan agreement, dated August 1, 2021, indicated R5 received medication management services. R5's Uniform Assessment Tool, dated January 3, 2021, indicated R5 received medication management under Section 1D: "Yes, staff administers and manages all medications." R5's medication management record lacked a description of: - identification of persons responsible for monitoring medication supplies and ensuring medication refills were ordered on a timely basis. During an interview on February 7, 2023 at 11:53 a.m., LALD-D said they were missing components to the medication management service records. A policy titled Medication Services, dated September 22, 2021, indicated medication services included procurement, storage, release,	01730		

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01730	Continued From page 20 destruction, documentation and reporting of side effects or errors consistent with standard nursing and pharmacy practice. No further information provided. TIME PERIOD TO CORRECT: Seven (7) Days.	01730		
01760 SS=F	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 interview and record review the licensee failed to ensure documentation in the resident records included 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, for two of two residents (R1 ad R2) reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or	01760		

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01760	Continued From page 21 safety but had the potential to have harmed a client'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 clients). Findings include: Review of R1's medical record revealed R1 was admitted to the licensee on December 5, 2022, with diagnoses including metabolic encephalopathy, hypertension and neuropathy. R1 was assessed by the nurse as having a history of falls. R1's Service Plan, dated December 5, 2022, indicated R1 received daily medication administration according to the electronic medication administration record (eMAR). R1's Medication Order Summary, dated November 2022 indicated R1 received prescribed Gabapentin 100 mg caps 3 times daily by mouth for idiopathic peripheral neuropathy. R1's medication management assessment, dated December 13, 2022, was completed by registered nurse (RN)-F and indicated staff administered and managed all of R1's medications three times daily. Review of R1's December MAR indicated she did not receive her prescribed scheduled doses of Gabapentin 100 mg caps for idiopathic peripheral neuropathy due to "awaiting med delivery" or "med not available" on: 12/5/22 2:00 p.m., 8:00 p.m. 12/6/22 8:00 am, 2:00 p.m., 8:00 p.m.	01760		

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01760	Continued From page 22 12/7/22 8:00 am, 2:00 p.m., 8:00 p.m. 12/8/22 8:00 a.m., 2:00 p.m., 8:00 p.m. 12/9/22 8:00 a.m., 2:00 p.m., 8:00 p.m. 12/10/22 8:00 a.m., 2:00 p.m., 8:00 p.m. 12/11/22 8:00 a.m., 2:00 p.m. 12/13/22 2:00 p.m., 8:00 p.m. 12/14/22 8:00 a.m., 2:00 p.m., 8:00 p.m. 12/15/22 8:00 a.m., 2:00 p.m., 8:00 p.m. 12/16/22 8:00 a.m., 2:00 p.m., 8:00 p.m. 12/17/22 8:00 a.m., 2:00 p.m., 8:00 p.m. 12/18/22 8:00 a.m., 2:00 p.m., 8:00 p.m. 12/19/22 8:00 a.m., 2:00 p.m., 8:00 p.m. 12/20/22 8:00 a.m., 2:00 p.m. Review of R1's medication record lacked follow up by a nurse on the undelivered prescription medication. Review of R2's medical record revealed R2 was admitted to the licensee on February 24, 2020, with diagnoses including type 2 diabetes mellitus and other signs and symptoms involving cognitive functions and awareness. R2's Service Plan Agreement with effective date of February 7, 2023, indicated R2 received medication management services including staff administering R2's medications. Review of R2's December 2022, MAR indicated she did not receive her prescribed clotrimazole 1% topical cream (anti-fungal) apply to affected areas twice daily, due to "awaiting med delivery" or "med not available" on: 12/9/22 at 8:00 a.m. and 8:00 p.m. 12/10/22 at 8:00 a.m. and 8:00 p.m. 12/11/22 at 8:00 a.m. and 8:00 p.m. 12/12/22 at 8:00 a.m. and 8:00 p.m. 12/13/22 at 8:00 a.m. and 8:00 p.m.	01760		

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01760	Continued From page 23 12/16/22 at 8:00 p.m. 12/20/22 at 8:00 a.m. and 8:00 p.m. 12/21/22 at 8:00 a.m. 12/29/22 at 8:00 a.m. Review of R2's January 2023, MAR indicated she did not receive her prescribed clotrimazole 1% topical cream, apply to affected areas twice daily, due to "awaiting med delivery" or "med not available" on: 01/01/23 at 8:00 a.m., 8:00 p.m. 01/15/23 at 8:00 a.m. and 8:00 p.m. Review of R2's January 2023, MAR indicated she did not receive her prescribed Pregabalin (treat nerve pain) 75 mg capsule twice daily by mouth for pain due to "awaiting med delivery" or "med not available" on: 01/08/22 at 8:00 a.m. 01/11/22 at 8:00 a.m. and 8:00 p.m. 01/12/22 at 8:00 a.m. and 8:00 p.m. 01/13/22 at 8:00 a.m. During an observation and interview on February 7, 2023 at 6:15 a.m., unlicensed personnel (ULP)-E said when a medication is running low or is out, she would electronically notify the nurses by selecting a refill option on a resident's electronic MAR screen. That message goes to the nurses and they are responsible for follow up on medication refills. A policy titled Medication Services, dated September 22, 2021, indicated medication services included procurement, storage, release, destruction, documentation and reporting of side effects or errors consistent with standard nursing and pharmacy practice.	01760		

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01760	Continued From page 24 A policy titled titled Documentation of Medication, Treatment and Therapy Management Services, 4. Receiving and Requesting Prescriptions and Refills, dated February 10, 2022, read: The nurse will document actions to implement a new prescription when it is received, and actions to request and obtain needed refills for residents, including communications with the prescriber, pharmacy, residents and/or resident's representative or family. No further information provided. TIME PERIOD TO CORRECT: Seven (7) Days.	01760		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of three residents (R2) reviewed with medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01880		

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01880	Continued From page 25 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Review of R2's medical record revealed R2 was admitted on February 24, 2020. R2's Uniform Assessment Tool dated January 10, 2023, identified by licensed assisted living director (LALD)-D as R2's most recent registered nurse (RN) assessment, read under Mediation Management, "D. Yes, staff administers and manages all medications." R2's Service Plan Agreement with effective date of February 7, 2023, indicated R2 received medication management services and directed staff to "make sure R2 takes her meds. Do not leave them next to her as she is sitting in the chair." On February 7, 2023, at approximately 7:00 a.m., observed unlicensed personnel (ULP)-E provide R2 medications per R2's medication administration record (MAR) provider orders. R2 was seated in a recliner in R2's living space. Observed next to R2's left arm was an end table with a basket in which a box of Imodium A-D (an over-the-counter anti-diarrhea medication). Additionally, inside R2's refrigerator was a plastic bag with a Basaglar (a long-acting insulin) Kwikpen (a insulin delivery system resembling a large pen) with an opened date of February 23, 2020. On February 7, 2023, at approximately 1:00 p.m., LALD-D stated all residents who receive medication management services should have all medications secured in the medication cart.	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34662	A. BUILDING: _____ B. WING _____	02/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD OF MINNETONKA	17710 OLD EXCELSIOR BOULEVARD MINNETONKA, MN 55345

(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
01880	Continued From page 26 LALD-D indicated the medication may have been provided to R2 by a visiting family member, but the ULPs are to remove medications when they are noted in R2's room. LALD-D indicated the medications would be removed immediately and secured in the medication cart. The licensee's Storage of Medications - Minnesota policy dated February 10, 2022, indicated medications would be stored based on the RN assessment and stored according to the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01880		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects	02110		

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02110	Continued From page 27 of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all the required policies and procedures that address dementia care for two of of two residents (R1 and R2) reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client and does not affect 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 clients). Findings include: Review of R1 and R2's records lacked documention that they or their representatives received the 10 policies and procedures related	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34662	A. BUILDING: _____ B. WING _____	02/08/2023

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HAVENWOOD OF MINNETONKA	17710 OLD EXCELSIOR BOULEVARD MINNETONKA, MN 55345

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02110	Continued From page 28 to dementia care at the time of move-in as required. On February 6, 2023 at 12:30 p.m. during a change in ownership (CHOW) survey, licensed assisted living director (LALD)-D indicated the licensee had previously (prior to CHOW) included the 10 policies and procedures for dementia care in the contract. After the CHOW, licensee accidently removed them and they would need to be added back in. LALD-D stated, "You'll just have to cite us for that." No further information provided. TIME PERIOD TO CORRECT: Twenty-one (21) Days.	02110		
02310 SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for one of three residents (R2) with bed rails. 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	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34662	A. BUILDING: _____ B. WING _____	02/08/2023

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02310	Continued From page 29	02310		

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:

Review of R2's medical record revealed R1 was admitted on February 24, 2020.

R2's Uniform Assessment Tool dated January 10, 2023, identified by licensed assisted living director (LALD)-D as R2's most recent registered nurse (RN) assessment, indicated under ADLs (activities of daily living) number 15, R2 used the following assistive equipment, "C. Walker: 2 Wheeled I. Over-the-toilet commode chair J. Shower Bench/Shower Chair."

During observations on February 7, 2023, at approximately 7:00 a.m., R2's bed had a black U-shaped consumer bed mobility device (often referred to as bed rails or grab bars) on the left side of R2's bed. The device was a single black pole with two feet on the floor and extending up into an upside down U or arch shaped. At approximately the midpoint of the arch shape, two additional black metal poles extended perpendicularly from the frame in between R2's mattress and box spring. A black strap appeared to wrap the entire box frame in an attempt to secure the bed mobility device frame to the box frame.

The surveyor was able to grab the top of the arch point and pull the entire bed mobility device frame away from the bed approximately 6" with ease. This created a hazardous space where a person could easily become entrapped between the bed

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	34662	A. BUILDING: _____ B. WING _____	02/08/2023

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02310	Continued From page 30 and the device. On February 7, 2023, at approximately 1:00 p.m., LALD-D provided a Physical Device Assessment dated February 7, 2023, completed by the RN and indicated the device was removed. LALD-D indicated R2 did not use the bed to sleep. LALD-D indicated R2 slept in their recliner and the device had never been used. LALD-D indicated R2's sister had provided the device but R2 preferred to sleep in their recliner. The licensee's Bedside Mobility Devices policy dated July 29, 2019, identified specific approved bedside mobility devices of which R2's was not included. Additionally, the policy indicated before any bedside mobility device was implemented or installed, an assessment on the resident's safety and risk and benefits would be reviewed. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days.	02310		

Minnesota Department of Health

625 Robert Street North
St Paul
651-201-4500

Type: Full
Date: *02/06/23*
Time: 11:51:46
Report: 7994231030

Food and Beverage Establishment Inspection Report

Location:
Havenwood Of Minnetonka Al
17710 Old Excelsior Boulevard
Minnetonka, MN55345
Hennepin County, 27

Establishment Info:
ID #: 0038467
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9522091440
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ** Priority 1 **

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW BEEF AND CHICKEN FOUND OVER THAWING COOKED CHICKEN IN THE WALK IN COOLER ON A SPEED RACK. MOVE RAW FOODS UNDER READY TO EAT FOODS.

Comply By: 02/06/23

3-400A Destroying Organisims: cooking time/temperature, freezing

3-401.11D(1)(2)

MN Rule 4626.0340D(1)(2) Discontinue offering raw or undercooked fish, shellstock, eggs, steak tartar or comminuted beef to a highly susceptible population which includes children.

SOME OVER EASY NON PASTEURIZED EGGS ARE SERVED IN THE FACILITY. DISCONTINUE THIS PRACTICE OR SWITCH TO PASTEURIZED EGGS.

Comply By: 02/10/23

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

THIS WAS AN UNANNOUNCED INSPECTION. I SPOKE WITH THE PERSON IN CHARGE ABOUT THIS REPORT AND ANY ITEMS WITHIN.

TEMPERATURES:
TOMATOES 40
LETTUCE 38
CHICKEN 38

VEGETABLES 147

EGG 182 (COOK)

SANITIZERS:
DISHWASHER 160

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 7994231030 of 02/06/23.

Certified Food Protection Manager: Sandra Key Chevalier

Certification Number: 97046 Expires: 01/16/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: Crystal Elva
Crystal Elva
Public Health Sanitarian 3
St Paul
651-201-3981
Crystal.Elva@state.mn.us

Report #: 7994231030

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
625 Robert Street North
St Paul

No. of RF/PHI Categories Out	2	**Date**	02/06/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:51:46
Legal Authority MN Rules Chapter 4626		**Time Out**	

Establishment	Address	City/State	Zip Code	Telephone
Havenwood Of Minnetonka Al	17710 Old Excelsior Boulevard	Minnetonka, MN	55345	9522091440

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038467		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
Surpervision						
1	(IN)	OUT		PIC knowledgeable; duties & oversight		
2	(IN)	OUT	N/A	Certified food protection manager, duties		
Employee Health						
3	(IN)	OUT		Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN)	OUT		Proper use of reporting, restriction & exclusion		
5	(IN)	OUT		Procedures for responding to vomiting & diarrheal events		
Good Hygenic Practices						
6	(IN)	OUT	N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN)	OUT	N/O	No discharge from eyes, nose, & mouth		
Preventing Contamination by Hands						
8	(IN)	OUT	N/O	Hands clean & properly washed		
9	(IN)	OUT	N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN)	OUT		Adequate handwashing sinks supplied/accessible		
Approved Source						
11	(IN)	OUT		Food obtained from approved source		
12	IN	OUT	N/A (N/O)	Food received at proper temperature		
13	(IN)	OUT		Food in good condition, safe, & unadulterated		
14	IN	OUT	(N/A) N/O	Required records available; shellstock tags, parasite destruction		
Protection from Contamination						
15	IN	(OUT)	N/A N/O	Food separated and protected		
16	(IN)	OUT	N/A	Food contact surfaces: cleaned & sanitized		
17	(IN)	OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status					COS	R
Time/Temperature Control for Safety						
18	IN	(OUT)	N/A N/O	Proper cooking time & temperature		
19	IN	OUT	N/A (N/O)	Proper reheating procedures for hot holding		
20	IN	OUT	N/A (N/O)	Proper cooling time & temperature		
21	(IN)	OUT	N/A N/O	Proper hot holding temperatures		
22	(IN)	OUT	N/A	Proper cold holding temperatures		
23	(IN)	OUT	N/A N/O	Proper date marking & disposition		
24	IN	OUT	(N/A) N/O	Time as a public health control: procedures & records		
Consumer Advisory						
25	IN	OUT	(N/A)	Consumer advisory provided for raw/undercooked food		
Highly Susceptible Populations						
26	(IN)	OUT	N/A	Pasteurized foods used; prohibited foods not offered		
Food and Color Additives and Toxic Substances						
27	IN	OUT	(N/A)	Food additives: approved & properly used		
28	(IN)	OUT		Toxic substances properly identified, stored, & used		
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:** 02/06/23

Inspector (Signature) Crystal Elva