Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF PROVISIONAL CONDITIONAL LICENSE - LICENSE GRANTED

Electronic Delivery

January 29, 2024

Licensee
Camilia Rose Assisted Living
11800 Xeon Boulevard Northwest
Coon Rapids, MN 55448

RE: Initial License Number 406767
Health Facility Identification Number (HFID) 38783
Project Number(s) SL38783015

Dear Licensee:

The Minnesota Department of Health (MDH) has completed a review of your facility's requested waiver connected to the June 16, 2023, survey of your facility and subsequent orders. The requested waiver has been approved and the facility is determined to be in substantial compliance. **Based on the waiver approval, the condition(s) on the license were removed effective January 29, 2024.**

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

In addition, this is your **official notice** that you have been **granted your assisted living facility with dementia care license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

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

Sincerely,

Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL PROVISIONAL LICENSE

Electronically Delivered

September 13, 2023

Licensee
Camilia Rose Assisted Living
11800 Xeon Boulevard Northwest
Coon Rapids, MN 55448

RE: Conditional Provisional License Number 406767
Health Facility Identification Number (HFID) 38783
Project Number(s) SL38783015

Dear Licensee:

The Minnesota Department of Health (MDH) completed an initial survey on June 16, 2023, for the purpose of assessing compliance with state licensing statutes and determine issuance of an initial license to the above mentioned provider. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is extending your provisional license for 90-days and applying conditions necessary to bring the facility to compliance. The conditional provisional license is due to expire on **December 12, 2023**.

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

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

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

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

Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

CONDITIONAL LICENSE ISSUED:

MDH will issue Camilia Rose Assisted Living a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Camilia Rose Assisted Living is in substantial compliance.

The following conditions apply on the provisional conditional assisted living facility license:

a. **Design requirements and plan submission:** Camilia Rose Assisted Living will submit documentation, within ten business days of receiving this notice, detailing the facility's plan to comply with Chapter 4.1 1-2.2.2.7 of the FGI which specifies each resident will have access to a bathroom containing an accessible shower. **Camilia Rose Assisted Living will submit the requested plan to Tim Hanna, Interim Assisted Living Engineering Supervisor, at tim.hanna@state.mn.us, on or before Wednesday, September 27, 2023.**

b. **Construction timeline:** Camilia Rose Assisted Living will begin plan implementation and physical construction to comply with Chapter 4.1 1-2.2.2.7 of the FGI within the 90 days of this conditional provisional license.

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:
MDH will determine if Camilia Rose Assisted Living is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Camilia Rose Assisted Living is in substantial compliance on the follow up survey, MDH will remove the conditions from Camilia Rose Assisted Living's assisted living facility license, and Camilia Rose Assisted Living will correct violations identified during the survey to come into substantial compliance. If MDH determines Camilia Rose Assisted Living is not in substantial compliance, MDH may take additional enforcement action against Camilia Rose Assisted Living, including placement of additional conditions, issuing an extension to the conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144G.20 up to and including immediate temporary suspension and revocation.

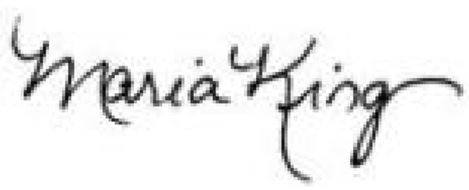
REQUESTING A HEARING:
Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. The request for hearing should be addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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 Rhylee Gilb directly at: 218-232-8285.

Sincerely,



Maria King, RN
Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38783	A. BUILDING: _____ B. WING _____	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMILIA ROSE ASSISTED LIVING	11800 XEON BLVD NW COON RAPIDS, MN 55448

(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 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: #SL38783015 On June 12, 2023 through June 14, 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 15 residents receiving services under the provider's Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 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, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 12, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it.	0 570		

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0 570	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the original, active license at the main entrance. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident 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 the residents). The findings include: During an observation on June 12, 2023 at 10:00 a.m., the licensee did not have an original, active license posted at its main entrance. During the entrance conference on June 14, 2023 at 12:35 p.m., director of quality improvement (DQI)-E stated he has the license in a file in his office. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 570		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the	0 630		

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0 630	Continued From page 3 person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the individual abuse prevention plan (IAPP) failed to included individualized interventions to prevent abuse and identify the resident risk for abusing others for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 admitted to the licensee March 9, 2023. R2's diagnoses included cerebral infarction and hemiplegia. R2's service plan dated March 9, 2023, indicated R2 received assistance with mobility, eating, and incontinence care. R2's IAPP dated June 11, 2023, identified R2 as at risk to be abused. This IAPP failed to include an intervention for this vulnerability. R2's IAPP did not address R2's risk of abusing other vulnerable adults and self-abuse. During an interview on June 13, 2023, at 2:30	0 630		

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0 630	Continued From page 4 p.m., registered nurse (RN)-B stated she was aware of the required content for the IAPP. The licensee-provided policy titled Individual Abuse Prevention dated June 5, 2023, indicated the IAPP would include the resident's vulnerabilities to abuse, neglect, and exploitation. This policy lacked verbiage identifying self-abuse of a vulnerability. TIME PERIOD FOR CORRECTION: Seven (7) Days	0 630		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the	0 730		

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0 730	Continued From page 5 resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a discharge summary for one of one residents (R4) reviewed.. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	0 730		

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0 730	Continued From page 6 R4 admitted to the licensee March 20, 2023. R2's diagnoses included encephalopathy. R4's service plan dated March 20, 2023, indicated R4 received services including medication administration, wound care, and oxygen management. R4 discharged from the licensee April 15, 2023. R4's record lacked a discharge summary. During an interview on June 13, 2023, at 2:30 p.m., registered nurse (RN)-B stated they did not have a discharge summary for R4. During the exit interview on June 14, 2023 at 12:35 p.m., director of quality improvement (DQI)-E stated they did not have a policy addressing required content of resident records. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	0 730		
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,	0 800		

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0 800	Continued From page 7 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). Findings include: On a facility tour on June 13, 2023, from approximately 10:00 a.m. to 1:00 p.m. with the Director of Quality Improvement (DQI)-E it was observed that the IT closet was missing the fire-stopping sealant around one of the through-ceiling sleeve penetrations. It was observed that the mechanical closet in the dining room was missing one of the ceiling tiles near the sprinkler head. Smoke and heat from a potential fire would gather at the higher ceiling in the plenum space, bypassing the sprinkler head and potentially not activating the sprinkler system. It was observed that the light switch in the storage room by the spa did not turn on the lights in the storage room. The switch was loose in the box, but the issue could also have been that the light bulbs were burnt out. It was observed that the trap in the hopper in the	0 800		

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0 800	Continued From page 8 soiled linen room was dry and sewer smells were filling the room. DQI-E 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. (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	0 810		

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0 810	Continued From page 9 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 a record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. 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 June 13, 2023, at approximately 1:00 p.m. with the Director of Quality Improvement (DQI)-E on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. The facility plan indicated to use	0 810		

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0 810	Continued From page 10 RACE acronym but was very vague and did not provide complete actions for employees to take in the event of a fire or similar emergency. During interview, DQI-E verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, DQI-E verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include 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. The facility plan did include some provisions for the relocation of residents but did not specify how to move or evacuate residents or identify the unique and unusual needs of the residents. During interview, DQI-E verified that the fire safety and evacuation plan for the facility lacked these provisions. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plan twice per year after the training at initial hire. During interview, DQI-E stated the licensee did not have any documented training of employees on the fire safety and evacuation plan. Record review of the available documentation indicated that the licensee did not provide annual training to residents who can assist in their own	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38783	A. BUILDING: _____ B. WING _____	06/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMILIA ROSE ASSISTED LIVING	11800 XEON BLVD NW COON RAPIDS, MN 55448

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0 810	Continued From page 11 evacuation on the proper actions to take in the event of a fire including movement, evacuation, or relocation as required by statute. During interview, DQI-E stated that the facility did not have documentation on offering resident training on the fire safety and evacuation plan. 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 drills were completed monthly since November 2022, but had only been completed once for second and third shift. All other evacuation drills had been completed on the first shift. During interview, DQI-E 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		
0 840 SS=F	144G.45 Subd. 4 Design requirements (a) All assisted living facilities with six or more residents must meet the provisions relevant to assisted living facilities in the 2018 edition of the Facility Guidelines Institute "Guidelines for Design and Construction of Residential Health, Care and Support Facilities" and of adopted rules. This minimum design standard must be met for all new licenses, or new construction. In addition to the guidelines, assisted living facilities shall provide the option of a bath in addition to a shower for all residents. (b) If the commissioner decides to update the edition of the guidelines specified in paragraph (a) for purposes of this subdivision, the	0 840		

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0 840	Continued From page 12 commissioner must notify the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health care and public safety of the planned update by January 15 of the year in which the new edition will become effective. Following notice from the commissioner, the new edition shall become effective for assisted living facilities beginning August 1 of that year, unless provided otherwise in law. The commissioner shall, by publication in the State Register, specify a date by which facilities must comply with the updated edition. The date by which facilities must comply shall not be sooner than six months after publication of the commissioner's notice in the State Register. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview the licensee failed to meet the provisions relevant to assisted living facilities in the 2018 edition of the Facility Guidelines Institute (FGI) "Guidelines for Design and Construction of Residential Health, Care and Support Facilities" and of adopted rules. This deficient condition had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 a facility tour on June 13, 2023, from	0 840		

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0 840	Continued From page 13 approximately 10:00 a.m. to 1:00 p.m. with the Director of Quality Improvement (DQI)-E it was observed that the resident apartments did not have a shower in the bathroom. Chapter 4.1-2.2.2.7 of the FGI states each resident shall have access to a bathroom containing an accessible shower. DQI-E visually verified these deficient findings at the time of discovery. Record review of the available documentation indicated that the licensee requested a waiver for providing showers in resident bathrooms stating that the facility was constructed to support individuals with high support needs, including physical assistance with bathing. Licensee stated that each of the floors had a bathing room to accommodate the needs for accessibility and personal care assistance. The waiver request was approved on April 15, 2022, for one year. The waiver expired on April 17, 2023. The licensee requested a second waiver for providing showers in resident bathrooms stating that this requirement is prohibitively expensive and would compromise the functional space in the existing bathrooms. The second waiver request was denied stating that during the first, approved waiver period, the facility should maintain communication with the Department of Health and make meaningful efforts to bring all assisted living rooms into compliance with the obligation that each assisted living room have its own shower. and the facility must become or remain compliant with all other existing Minnesota building codes applicable to the building and assisted living licensure during the period of this waiver, including areas outlined in the engineering inspection letter dated March 31, 2022. The waiver was denied on April 27, 2022. There are no further records regarding the waiver	0 840		

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0 840	Continued From page 14 request or an attempt to appeal by the licensee. Record review of the available documentation indicated that the licensee did not come into compliance with the areas outlined in the engineering inspection letter dated March 31, 2022. Licensee failed to provide requested documentation confirming the building systems complied with ASHRAE 62.2 and NFPA 99 for the building heating, ventilation, and air conditioning (HVAC), electrical, and plumbing systems. During interview, DQI-E stated that they had worked with a mechanical and structural engineer to find a solution for the showers in the resident apartments, but had been told by the structural engineer that the building structure could not support the additional load of the showers and plumbing required for them. DQI-E could not provide any documentation of the conversation or results of the structural analysis. DQI-E also stated that they were testing a portable shower system that connected to the sink in the resident bathrooms, but the size and location of the portable shower would reduce the required clear floor space for the accessible toilet in the bathroom. The portable showers also did not meet accessibility requirements for showers located in the FGI and other Minnesota building codes or the Minnesota Accessibility Code. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 840		
0 850 SS=F	144G.45 Subd. 5 Assisted living facilities; Life Safety Code	0 850		

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0 850	Continued From page 15 (a) All assisted living facilities with six or more residents must meet the applicable provisions of the 2018 edition of the NFPA Standard 101, Life Safety Code, Residential Board and Care Occupancies chapter. The minimum design standard shall be met for all new licenses or new construction. (b) If the commissioner decides to update the Life Safety Code for purposes of this subdivision, the commissioner must notify the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health care and public safety of the planned update by January 15 of the year in which the new Life Safety Code will become effective. Following notice from the commissioner, the new edition shall become effective for assisted living facilities beginning August 1 of that year, unless provided otherwise in law. The commissioner shall, by publication in the State Register, specify a date by which facilities must comply with the updated Life Safety Code. The date by which facilities must comply shall not be sooner than six months after publication of the commissioner's notice in the State Register. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview the licensee failed to meet the provisions of the 2018 edition of the NFPA Standard 101, Life Safety Code, Residential Board and Care Occupancies chapter. This deficient condition had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 850		

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0 850	Continued From page 16 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: A record review and interview were conducted on June 13, 2023, at approximately 1:00 p.m. with the Director of Quality Improvement (DQI)-E on the missing life safety code building information requested in the engineering inspection letter dated March 31, 2023. The licensee failed to provide the requested life safety code plan that included the locations of smoke compartments, the location and rating of fire partitions, fire door and egress door sizes and ratings, and corridor widths. Licensee also failed to confirm the intended use of existing soiled linen rooms and failed to verify if the room construction met the required 1-hour separation. During interview, DQI-E stated he would work on getting the information submitted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 850		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an	01610		

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01610	Continued From page 17 initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete a nursing assessment of the resident on or before move-in for one of three residents (R2) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2 admitted to the licensee March 9, 2023. R2's diagnoses included cerebral infarction and hemiplegia. R2's service plan dated March 9, 2023, indicated R2 received assistance with mobility, eating, and incontinence care.	01610		

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01610	Continued From page 18 R2's record lacked a nursing assessment completed on or before March 9, 2023. R2's record included an admission assessment dated March 13, 2023. During the entrance conference on June 12, 2023 at 10:20 a.m., registered nurse (RN)-B stated they completed pre-admission assessments, in person or virtually. The licensee-provided policy titled Comprehensive Assessments and the Care Delivery Process dated February 25, 2022 indicated comprehensive assessments would be conducted but failed to address this requirement set forth in Minnesota Statutes 144G. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days	01610		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of	01620		

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01620	Continued From page 19 services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to complete 14-day assessments on three of three residents (R1, 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) 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). During the entrance conference on June 12, 2023 at 10:20 a.m., registered nurse (RN)-B stated they completed 14-day assessments. R1 admitted to the licensee February 25, 2023. R1's diagnoses included encephalopathy and seizure disorder. R1's service plan dated February 23, 2023 indicated R3 received assistance with toileting and ambulating with a walker. R1's record included an initial assessment dated February 23, 2023.	01620		

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01620	Continued From page 20 R1's record lacked a 14-day assessment due no later than March 11, 2023. R2 admitted to the licensee March 9, 2023. R2's diagnoses included cerebral infarction and hemiplegia. R2's service plan dated March 9, 2023, indicated R2 received assistance with mobility, eating, and incontinence care. R2's record included an admission assessment dated March 13, 2023. R2's record lacked a 14-day assessment due no later than March 23, 2023. R3 admitted to the licensee November 8, 2022. R3's diagnoses included hypothyroidism and generalized weakness. R3's service plan dated June 13, 2023 indicated R3 received assistance with medication administration. R3's record lacked a 14-day assessment due no later than November 22, 2022. On June 13, 2023 at 9:30 a.m., the surveyor requested R3's initial assessment, 14-day assessment, and 90-day assessment. The licensee provided assessments dated March 14, 2023 and June 13, 2023. The licensee-provided policy titled Comprehensive Assessments and the Care Delivery Process dated February 25, 2022 indicated the Minimum Data Set would be completed within 14 days after admission but failed to address this requirement set forth in Minnesota Statutes 144G. TIME PERIOD FOR CORRECTION: Twenty-One	01620		

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01620	Continued From page 21 (21) Days	01620		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to ensure one medication had a label for one of three residents (R1), and one had a legible label for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: NO LABEL R1 admitted to the licensee February 25, 2023. R1's diagnoses included chronic obstructive pulmonary disease (COPD). R1's service plan dated February 23, 2023, indicated R3 received assistance with toileting and ambulating with a walker. A nursing assessment dated May 30, 2023, indicated R1 received medication	01890		

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01890	Continued From page 22 administration. R1's medication list included Incruse Ellipta Inhaler (a medication that works by relaxing muscles in the airway to improve breathing) 62.5 micrograms (mcg) one puff inhaled orally every morning. During an observation on June 13, 2023, at 8:00 a.m., R1's Incruse inhaler lacked a prescription label. ILLEGIBLE LABEL R3 admitted to the licensee November 8, 2022. R3's diagnoses included hypothyroidism and generalized weakness. R3's service plan dated June 13, 2023, indicated R3 received assistance with medication administration. R3's medication list included artificial tear eye drops two drops to both eyes up to four times daily as needed. During an observation on June 13, 2023, at 8:10 a.m., R3's artificial tears eye drops had an illegible label attached to the bottle. The licensee-provided policy Medication and Treatment Orders dated October 21, 2022, did not address this requirement in accordance with Minnesota Statutes 144G. TIME PERIOD FOR CORRECTION: Seven (7) Days	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment	02040		

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02040	Continued From page 23 An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment with mitigation factors on and around the property for the facility. This deficient practice had the ability 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 June 13, 2023, at approximately 1:00 p.m. with the Director of Quality Improvement (DQI)-E on the hazard vulnerability assessment for the	02040		

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02040	Continued From page 24 physical environment of the facility. Record review of the available documentation indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, DQI-E verified that the licensee was not able to provide a hazard vulnerability assessment with mitigation factors for the physical environment on and around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *06/12/23*
Time: 10:30:44
Report: 1029231130

Food and Beverage Establishment Inspection Report

Location:

Camilla Rose Assisted Living
11800 Xeon Boulevard NW
Coon Rapids, MN55433
Anoka County, 02

Establishment Info:

ID #: 0041333
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/23

Operator:

Phone #:
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.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TCS ITEMS IN UPSTAIRS REFRIGERATOR MEASURED IN THE DANGER ZONE. ITEMS DISCARDED. INSTRUCTED ESTABLISHMENT TO NOT USE REFRIGERATOR FOR TCS ITEMS UNTIL PROPER HOLDING TEMPERATURES ARE VERIFIED.

Comply By: 06/14/23

4-500 Equipment Maintenance and Operation

4-501.114C3 ***** Priority 1 *****

MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.

QUATERNARY AMMONIUM CONCENTRATION IN SANITIZER BUCKET MEASURED 0 PPM. CORRECTED DURING INSPECTION TO 200 PPM.

Comply By: 06/14/23

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

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

NO METHOD OF INDEPENDENTLY TESTING MAX WATER TEMPERATURES IN DISH MACHINE. INSTRUCTED ESTABLISHMENT TO USE TEMP STICKERS OR AN IRREVERSIBLE

THERMOMETER TO INDEPENDENTLY VERIFY TEMPERATURES.
Comply By: 06/14/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
ESTABLISHMENT INDICATED THEIR CFPM IS JODY MASON BUT THERE IS NO EVIDENCE OF JODY'S CFPM CERTIFICATE. EMPLOY CFPM.
Comply By: 06/16/23

4-600 Cleaning Equipment and Utensils

4-602.11E

MN Rule 4626.0845E Clean surfaces contacting food that is not TCS: 1. at any time when contamination may have occurred; 2. at least once every 24 hours for iced tea dispensers and consumer self-service utensils; 3. before restocking consumer self-service equipment and utensils such as condiment dispensers, and display containers; 4. at a frequency specified by the manufacturer or at a frequency necessary to preclude accumulation of soil or mold for ice bins, beverage dispensing nozzles, enclosed components of ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment.
MOLD BUILDUP IN ICE MACHINE. INSTRUCTED ESTABLISHMENT TO CLEAN AND MAINTAIN CLEAN.
Comply By: 06/14/23

6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces.
ABSORBENT OFFICE CEILING TILES IN KITCHEN. SOME ARE BOWING. INSTRUCTED ESTABLISHMENT TO REPLACE WITH NON-ABSORBENT EASILY CLEANABLE MATERIAL.
Comply By: 06/14/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.
SEALANT BETWEEN WALL AND BACK PREP TABLE FRAYED. INSTRUCTED ESTABLISHMENT REPAIR.
Comply By: 06/14/23

Surface and Equipment Sanitizers

QUATERNARY AMMONIUM: = 0 PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: Yes

QUATERNARY AMMONIUM: = 200 PPM at Degrees Fahrenheit
Location: DISPENSER
Violation Issued: No

HOT WATER: = at 165.9 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MARGARINE
Temperature: 37 Degrees Fahrenheit - Location: WALK-IN COOLER
Violation Issued: No

Process/Item: LACTOSE FREE MILK
Temperature: 54 Degrees Fahrenheit - Location: UPSTAIRS REFRIGERATOR
Violation Issued: Yes

Process/Item: LOWFAT MILK
Temperature: 50 Degrees Fahrenheit - Location: UPSTAIRS REFRIGERATOR
Violation Issued: Yes

Process/Item: NUTRITION SHAKE
Temperature: 52 Degrees Fahrenheit - Location: UPSTAIRS REFRIGERATOR
Violation Issued: Yes

Process/Item: NUTRITION SHAKE
Temperature: 52 Degrees Fahrenheit - Location: UPSTAIRS REFRIGERATOR
Violation Issued: Yes

Process/Item: LOWFAT MILK
Temperature: 51 Degrees Fahrenheit - Location: UPSTAIRS REFRIGERATOR
Violation Issued: Yes

Process/Item: CHOCOLATE MILK
Temperature: 52 Degrees Fahrenheit - Location: UPSTAIRS REFRIGERATOR
Violation Issued: Yes

Process/Item: CHOCOLATE MILK
Temperature: 52 Degrees Fahrenheit - Location: UPSTAIRS REFRIGERATOR
Violation Issued: Yes

Process/Item: INTERNAL THERMOMETER
Temperature: 50 Degrees Fahrenheit - Location: UPSTAIRS REFRIGERATOR
Violation Issued: No

Process/Item: SHELL EGGS
Temperature: 53 Degrees Fahrenheit - Location: UPSTAIRS REFRIGERATOR
Violation Issued: Yes

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

Conducted inspection of food services area as part of a Health Regulation Division survey.

Conducted inspection primarily in the presence of Jane Strobel; Jenny Jurgensen, Housekeeping-Dietary; and Marie Wortman, Cook-Kitchen Lead; and other staff members. Topics discussed with staff included

highly susceptible populations, employee illness reporting and exclusion procedures, vomit/fecal matter cleanup, sanitizing, common contagious foodborne illness pathogens (e.g., salmonella, shigella, Shiga toxin-producing E. coli, hepatitis A virus, and norovirus), hygienic practices (e.g., handwashing), and general food safety practices (e.g., holding temperatures at or below 41°F and 135°F or above for TCS foods).

Primary kitchen was commercial in nature and in fair to good condition.

All findings were discussed with staff during and after the inspection.

Report emailed to Nicole Myslicki, RN, Special Investigator, Nurse Evaluator, following the inspection.

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 1029231130 of 06/12/23.

Certified Food Protection Manager: Vacant

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____

Marie Wortman
Cook - Kitchen Lead

Signed: _____

Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029231130

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	3
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 06/12/23
Time In 10:30:44
Time Out

Camilla Rose Assisted Living	Address: 11800 Xeon Boulevard NW	City/State: Coon Rapids, MN	Zip Code: 55433	Telephone
License/Permit #: 0041333	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	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	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:** 06/14/23

Inspector (Signature) Trevor L McClimint