Electronically Delivered

April 20, 2023

Licensee
Eastwood Assisted Living
170 Valhalla Circle
Mora, MN 55051

RE: Project Number(s) SL30743015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 29, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

The correction order documentation should include the following:

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

the specific statute(s).

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

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

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

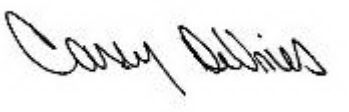
Please address your cover letter for reconsideration requests to:

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

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30743	A. BUILDING: _____ B. WING _____	03/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTWOOD ASSISTED LIVING	170 VALHALLA CIRCLE MORA, MN 55051

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30473015-0 On March 27, 2023, through March 29, 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 31 residents receiving services under the Assisted Living with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following	0 680		

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0 680	Continued From page 1 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. (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 practice and document testing of its emergency preparedness (EP) plan at least twice annually as required. In addition, the licensee failed to evaluate/revise its missing person policy at least quarterly. This had the potential to affect all residents receiving services under the assisted living with dementia care license, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 680		

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0 680	Continued From page 2 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 27, 2023, at 11:31 a.m., the evaluator requested to view the facility's EP plan, missing resident plan and related documentation, which the licensee later provided. The evaluator reviewed the licensee's EP plan, revised March 1, 2022, and accompanying documents. The plan lacked evidence the licensee tested its EP plan or conducted a full-scale exercise and/or participated in a tabletop exercise to test its plan and document the results of testing at least twice annually as required. The evaluator also reviewed the licensee's Missing Resident Emergency Operations policy, revised March 1, 2022. There was documentation of two facility drills of the missing resident plan, one dated December 28, 2022, at 10:10 a.m., and another dated January 16, 2023, at 4:30 p.m. The plan lacked evidence of any additional drills or evidence the licensee reviewed or updated the missing resident plan at least quarterly. On March 29, 2023, at 4:03 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she was familiar with and aware of the requirements for testing of the emergency preparedness plan and missing resident plan. LALD/RN-A said for some time she	0 680		

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0 680	Continued From page 3 has been a "one-person show" and it was difficult to caught up and complete all requirements. LALD/RN-A said there were missing reviews and testing of the emergency plan, but added we hired additional staff to relieve me of some of my duties sot that we can complete what is required. The licensee's Missing Resident Emergency Operations policy, revised March 1, 2022, indicated under procedures directed quarterly reviews of the missing resident policy with documented changes to the plan by the director of nursing/director of health services and administrator/executive director. The licensee's Emergency Preparedness Training, Drills and Exercise Plan 2022 - 2023 document, undated, indicated the licensees' training and testing plan complies with State and Federal requirements and is based on risks identified in the hazard vulnerability assessments. The policy indicated facilities will conduct one full-scale community-based exercise and one other exercise annually. The document indicated emergency drill documentation included notes from participant debriefing and improvement plan for each drill and annual drill log that includes date/time/location-scenarios/shift. The policy also indicated evacuation and missing resident drills must account for two drills each per shift per year, with at least one evacuation drill every other month. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 800	Continued From page 4	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On March 29, 2023, between 10:00 a.m. and 12:00 p.m., survey staff toured the facility with Director of Environmental Services (RES)-K and Maintenance Technician (MT)-J. During the facility tour, survey staff observed that the door closer on the exit door in the northwest corner of	0 800		

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0 800	Continued From page 5 the kitchen was missing. The missing door closer was verified by RES-K and MT-J accompanying on the facility tour. 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 twice per year per shift with at least one evacuation drill every other month. Evacuation of	0 810		

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0 810	Continued From page 6 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 conduct the required amount of evacuation drills. 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on March 29, 2023 at approximately 12:00 p.m. with the Regional Director of Environmental Services (RES)-K, Executive Director (RN) and Maintenance Technician (MT)-J on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. 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 no evacuation dills were conducted between the months of June 2022 through August 2022 and December 2022 through February 2023.	0 810		

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0 810	Continued From page 7 On March 29, 2023, at approximately 1:45 p.m., during the interview, the RES-K and RN verified these deficient conditions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.	01700		

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01700	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted an individualized medication assessment with the required content for three of three residents (R2, R3, R4) who received 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 27, 2023, at 11:10 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated the licensee provided medication management services to the licensee's residents. R2, R3 and R4's records lacked evidence the RN conducted a medication assessment to include: - identification and review of all medications the resident is known to be taking; -indications for medications; -side effects; -contraindications; and -allergic or adverse reactions, and actions to address these issues. R2 R2's revised service plan, signed by R2's	01700		

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01700	Continued From page 9 representative March 28, 2023, indicted R2's services included medication management. On March 28, 2023, at 7:24 a.m., the evaluator observed unlicensed personnel (ULP)-F administer medications to R2. R2's prescriber orders, signed January 4, 2023, included a pain reliever, skin protectant ointment, medications to treat dementia and Parkinson's symptoms, one antidepressant, and two inhaled medications for asthma. R2's most recent review dated March 24, 2023, which included medication assessment, lacked the content listed above. R3 R3's service plan, signed by the resident on March 2, 2023, indicted R3 received medication management services. On March 28, 2023, at 7:14 a.m., the evaluator observed ULP-F administer medications to R3. R3's prescriber orders, signed March 1, 2023, included a low-dose daily aspirin for heart health, a topical pain gel, one blood pressure medication, a medication for hyperlipidemia, three supplements and eye drops. R3's initial comprehensive assessment, dated February 28, 2023, which included medication assessment, lacked the content listed above. R4 R4's service agreement, dated December 27, 2022, indicated R4 received medication management services.	01700		

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01700	Continued From page 10 On March 28, 2023, at 7:44 a.m., the evaluator observed ULP-F obtain a blood sugar from R4 and administer the resident's morning medications. R4's prescriber orders, signed January 4, 2023, included daily insulin, a blood pressure medication, a medication for cholesterol and antiplatelet medication heart health. R4's most recent review dated March 9, 2023, which included medication assessment, lacked the content listed above. On March 29, 2023, at 3:30 p.m., LALD/RN-A acknowledged the comprehensive assessment for medications lacked the required content and said medications were not listed and there nothing on the form to verify that medications were reviewed. LALD/RN-A said she "reviews all meds (medications) and supplements" before a resident begins services, but that was not reflected on the assessment. LALD/RN-A said this was the format she used to complete all resident assessments. On March 29, 2023, at 3:55 p.m. p.m., regional director of clinical services (RDCS)-L said although not listed on the comprehensive assessment, the clinical nurses review resident medications and reconcile them upon admission. RDCS-L said medications were entered into the electronic record system in the "service module" where the medication name, dose, potential side effects, contraindications are noted and this was done for all prescribed and over-the-counter medications. RDCS-L said currently this information does not print out on the comprehensive assessment, but added she made changes to the comprehensive	01700		

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01700	Continued From page 11 assessment form. RDCS-L said going forward, the nurse will have to review and acknowledge a resident's current medications before the nurse can sign off and lock the assessment. RDCS-L stated this would now be included in every quarterly and significant change of condition assessment. The licensee's Medication Management Services Assisted Living policy, dated September 29, 2022, indicated for each resident who requests medication management services a registered nurse will conduct an assessment to determine what services will be provided. The policy indicated the assessment must include identification and review of all medication the resident is know to be taking, indications for medications, side effects, contraindications, allergic or adverse reactions and actions to address these issues. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *03/27/23*
Time: 11:30:00
Report: 1017231072

Food and Beverage Establishment Inspection Report

Location:
Eastwood Assisted Living
170 Valhalla Circle
Mora, MN55051
Kanabec County, 33

Establishment Info:
ID #: 0038591
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3206792916
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Hot Water: = at 170 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Quaternary Ammonia: = at 200 Degrees Fahrenheit
Location: QUAT LOCATED AT 3 COMP
Violation Issued: No

Quaternary Ammonia: = at 200 Degrees Fahrenheit
Location: QUAT LOCATED IN WIPING CLOTH BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 165 Degrees Fahrenheit - Location: EGG ROLLS LOCATED IN OVEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK LOCATED IN 2 DOOR UPRIGHT COOLER
Violation Issued: No

Process/Item: Hot Holding
Temperature: 174 Degrees Fahrenheit - Location: BEANS LOCATED IN HOT HOLDING STEAM TABLE

Violation Issued: No

Process/Item: Hot Holding
Temperature: 199 Degrees Fahrenheit - Location: RICE LOCATED IN HOT HOLDING STEAM TABLE

Violation Issued: No

Type: Full
Date: *03/27/23*
Time: 11:30:00
Report: 1017231072
Eastwood Assisted Living

Food and Beverage Establishment Inspection Report

Process/Item: Cooking
Temperature: 43 Degrees Fahrenheit - Location: TACO MEAT LOCATED IN 2 DOOR UPRIGHT
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: PERSONAL USE YOGURT MEMORY CARE UPRIGHT COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: MILK LOCATED IN UPRIGHT HALLWAY BY KITCHEN
Violation Issued: No

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

DISCUSSION:

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG.

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 1017231072 of 03/27/23.

Certified Food Protection Manager: NANCY B. STRUWVE

Certification Number: FM113426 Expires: 09/22/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
NATE TOPP
PUBLIC HEALTH SANITARIAN
ST. CLOUD
320.223.7333
NATE.TOPP@STATE.MN.US

Report #: 1017231072

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975

No. of RF/PHI Categories Out	0	**Date**	03/27/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	11:30:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

Eastwood Assisted Living	**Address** 170 Valhalla Circle	**City/State** Mora, MN	**Zip Code** 55051	**Telephone** 3206792916
License/Permit # 0038591	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

			COS	R
Proper Use of Utensils				
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
Utensil Equipment and Vending				
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
Physical Facilities				
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 03/28/23

Inspector (Signature)